STATE OF CALIFORNIA
DEPARTMENT OF INSURANCE
45 Fremont Street, 24th Floor
San Francisco, California 94105

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INITIAL STATEMENT OF REASONS

Reinsurance Oversight Regulations

INTRODUCTION

California Insurance Commissioner John Garamendi (the "Commissioner") proposes to add to California Code of Regulations, Title 10, Chapter 5, Subchapter 3, Article 3, the new Section 2303, entitled the "Reinsurance Oversight Regulations." The proposed regulations set forth the principal requirements of substance and procedure in accounting for reinsurance on insurer financial statements, the general requirements applicable to reinsurance agreements, and related sanctions and oversight.

Reinsurance is insurance for insurers. Reinsurance permits an insurer to share the risk it assumes on policies it writes, with one or more other insurers called "reinsurers". A reinsurance contract permits an insurer (the "direct writer") to transfer to a reinsurer a portion of the risk of loss arising from the underlying policies, in exchange for a portion of the premium earned on those policies. The direct writer remains directly liable to the policyholders for all losses; the reinsurer's obligation under the reinsurance contract is to indemnify the direct writer, not the policyholders, for the portion of the risk it has assumed.

In certain lines of business, spreading the risk of loss with one or more reinsurers reduces the possibility of an insurer's insolvency caused by a catastrophe such as an earthquake or a hurricane. The reinsurer may itself share the risk of business it has assumed with one or more other reinsurers, further spreading the risk of losses covered by the underlying policies. Reinsurance also serves other needs of insurers, including reducing ratios and improving other financial measures imposed by regulators to control an insurer's operations. The reduction in certain ratios, such as the ratio of premium written to surplus, would permit the insurer to write more business.

A significant part of these regulations concern the proper accounting for reinsurance on insurer statutory financial statements. Such statements are prepared in accordance with statutes designed to conservatively test solvency from the policyholder standpoint. The rules governing statutory accounting are designed to minimize the risk to an insurer's policyholders and creditors.

Providing that specified requirements are met, a ceding insurer is allowed to reduce its liabilities to policyholders on its financial statements (and also reduce the assets required for support of those liabilities) by the amount of those liabilities ceded to a reinsurer. The liabilities and the supporting assets are transferred to and carried on the books of the reinsurer to cover its share of the assumed loss. Regulators are assured that, as between the two companies, there are sufficient assets supporting the liabilities to policyholders.

Quality reinsurance protects the solvency of licensed insurers and thus promotes a healthy insurance market. The proposed regulations are intended to provide a regulatory framework to assess and ensure the quality of a licensee's reinsurance arrangements.

SPECIFIC PURPOSE AND REASONABLE NECESSITY

Sections 2303.3 through 2303.10 generally conform to the NAIC Model Credit for Reinsurance Regulation ("Model Regulation") and replace Bulletin 97-5, which was based on the then current Model Regulation and promulgated in 1997 pursuant to California Insurance Code ("Code") Section 928.8(a). Except in circumstances noted within this document, the text of these sections generally copies the text of the Model Regulation. Additional requirements have been included to conform the sections to California law, and in several instances additional requirements have been included to improve safeguards for licensees. Non-substantive changes have also been made in formatting and numbering. The Model Regulation has been adopted by most states. The sections of the regulations based on the Model are reasonably necessary to promote uniformity of standards among the different states to the extent possible under California law.

Sections 2303.11 through 2303.15 set forth the requirements for reinsurance agreements of licensees and the manner in which the Commissioner will exercise oversight. These sections are reasonably necessary to safeguard the solvency of licensees by ensuring that their reinsurance arrangements are satisfactory and meet statutory requirements.

The specific purpose of each regulation and the rationale for the Insurance Commissioner's determination that each regulation is reasonably necessary to carry out the purpose for which it is proposed are set forth below. Implementation of these regulations is necessary for the efficient administration and enforcement of the Code.

§2303 REINSURANCE ACCOUNTING, AGREEMENTS AND OVERSIGHT

This section sets forth the scope of the regulations as including the principal requirements of substance and procedure in accounting for reinsurance on insurer financial statements, the general requirements applicable to reinsurance agreements, and related sanctions and oversight. The section specifies that all insurers licensed or accredited in California, the approved U.S. trusts of otherwise unauthorized reinsurers, and licensed reinsurance intermediaries are subject to the regulations. The section is reasonably necessary to inform affected persons of the scope and application of the regulations.

§2303.1 PURPOSE

This section specifies the several general purposes of the proposed regulations. One purpose of the regulations is to specify the requirements for the proper and uniform preparation by licensed insurers of the financial statements required by the Code, and to specify requirements for acceptable reinsurance arrangements. The requirements are intended to elicit from insurers a true exhibit of their financial condition and to safeguard the solvency of licensees.

Another purpose of the regulations is to give notice as to the manner in which the Commissioner will exercise the discretion set forth in specified statutes as respects accounting for reinsurance in insurer financial statements, acceptable reinsurance arrangements, and regulatory oversight.

The section specifies that the duties and the discretion of the Commissioner conferred by statute to ensure proper accounting for reinsurance and oversight of reinsurance arrangements are not exhausted by these regulations.

The section is reasonably necessary to specify the general purposes of the regulations and to affirmatively state that the regulations do not exhaust the duties and discretion conferred upon the Commissioner by statute to ensure proper accounting for reinsurance and oversight of reinsurance arrangements.

§2303.2 DEFINITIONS

This section provides definitions to words and terms used throughout the regulations. Although many of the words and terms defined have a generally understood meaning in the insurance industry, definitions of those words and terms are included to avoid any ambiguity or uncertainty in the application of the regulations. For example, requirements made applicable only to a "domestic insurer" would not be applicable to a "foreign insurer", even though both insurers are licensees subject to the regulations. Definitions in this category include "accredited reinsurer," "alien insurer," approved U.S. trust," "U.S. trust," "assuming insurer," "reinsurer," "ceding insurer," "Commissioner," "Department," "domestic insurer," "domestic ceding insurer," "financial statements," "foreign ceding insurer," "foreign insurer," "insurer," "licensed insurer," "NAIC," "NAIC Accounting Guidance," "RBC Report," "reinsurance contract," "reinsurance agreement," "reinsurance treaty," "reinsurance intermediary," "intermediary," and "unauthorized reinsurer." These definitions are reasonably necessary to inform affected persons of the specific applicability and specific meaning of various requirements.

However, certain of the definitions are used to encompass concepts that may not be readily apparent from the word or term used. These definitions are discussed below.

§2303.2(j) "Examine" and "examination" are words used in Code Section 730 et seq. concerning the examination of licensees; however, the words are not defined. The examination statutes specify the procedures to be followed in conducting the full examination

of a licensee, which is performed periodically, usually every three to five years, by an examiner sent to the offices of the licensee. Code Section 730(b) allows the Commissioner to determine the nature, scope and frequency of examinations. The Commissioner has determined that oversight of licensee operations and transactions requires more frequent and more focused examinations than the periodic full examinations. These limited examinations include the review of a licensee's financial statements, reinsurance transactions, and other reports and documents by Department staff at Department offices.

Examinations conducted at Department offices are more efficient and less burdensome to both the Department and licensees, and avoid the necessity of sending examiners to the offices of insurers, which generally are not located within California. Since licensees are required by Code Section 736 to pay all costs of examination, examinations performed in Department offices provide a significant cost saving to licensees as well as reduce the number of examination personnel required to be employed by the Department.

"Examine" and "Examination" are defined in this section as including an examination or review of any nature, scope or frequency by the Department of a licensed insurer regardless of the location of the review or examination. The definition is reasonably necessary to clarify that "examine" and "examination" as used in the regulations have a meaning more broad than the full examination periodically performed at an insurer's premises. This definition is reasonably necessary to clarify and make specific Code Sections 730 and 736.

§2303.2(o) "Liabilities" is defined to include assumed modified coinsurance reserves and excludes ceded modified coinsurance reserves. In modified coinsurance, the ceding insurer transfers the risks, but holds the assets and establishes the reserves on behalf of the reinsurer. Since the risks have been transferred to the reinsurer, it is appropriate to require the corresponding reserves held by the ceding insurer to be accounted for in the same manner as reserves that are transferred to a reinsurer under coinsurance. This definition is necessary to properly measure the amount of business that is being assumed and/or ceded. This subdivision is reasonably necessary to clarify and make specific the requirements of Code Section 923.

§2303.2(q) "Material reinsurance agreement" is defined to mean a reinsurance agreement in which the reinsurance premium or a change in the ceding insurer's liabilities equals or exceeds 5 percent of the ceding insurer's policyholder surplus, as of the preceding December 31st. The definition provides that where the ceding insurer has more than one agreement with the same reinsurer, or more than one agreement with reinsurers within the same group of insurers, then the multiple agreements shall be considered as one agreement for the purpose of calculating the 5% threshold. If the threshold is met, then each of the multiple agreements is a "material reinsurance agreement."

The Commissioner has determined that a transaction that equals or exceeds 5% of an insurer's policyholder surplus is material to an insurer's operations and financial condition. Various regulations are limited in application to material reinsurance agreements in order to reduce the compliance burden on licensees as well as to reduce the oversight burden on the

Department. This definition is reasonably necessary to inform affected persons of those reinsurance agreements that are subject to a particular regulation.

§2303.2(r) "Materially deficient" is the term used in Code Section 717 as the basis for a finding by the Commissioner that an applicant does not meet the requirements for licensing. In considering license qualifications, Code Section 717(d) requires the Commissioner to evaluate an applicant's reinsurance arrangements to determine whether the arrangements are materially deficient. Once licensed, Code Section 700(c) requires a licensee to continue to meet admission requirements; i.e., as relevant here, to maintain reinsurance arrangements that are not materially deficient.

The term "materially deficient" is not defined in the Code. The regulations define the term with respect to reinsurance arrangements as those that (1) include one or more material reinsurance agreements for which statement credit is claimed that are not in compliance with the requirements of this article, or (2) result in a policyholder surplus that is not reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs, or (3) are not satisfactory to the Commissioner on the basis that he is unable to make a determination that the arrangements pose no undue risk to the ceding insurer, its policyholders or its creditors.

With respect to condition (1), the regulations are intended to safeguard solvency by, *inter alia*, requiring the uniform preparation of financial statements and specifying the requirements for satisfactory reinsurance arrangements. Uniform preparation of financial statements and satisfactory reinsurance arrangements are necessary for assessment of the true financial condition of licensees; moreover, they ensure a level playing field among insurers. If one or more material reinsurance agreements are not in compliance with applicable requirements, those objectives are likely defeated, perhaps exposing the insurer to an undue risk of financial hazard or insolvency, or hampering oversight by obscuring the true financial condition of the insurer, or permitting the insurer to improperly state its financial condition and gain competitive advantage.

With respect to condition (2), reinsurance arrangements that result in a surplus level that is not reasonable in relation to its outstanding liabilities or inadequate for its financial needs may result in an insurer's financial impairment or insolvency. Such a surplus would be insufficient to safeguard the insurer's solvency if, for example, it experienced an unexpected and significant adverse loss development, or its primary reinsurer became insolvent or refused to pay a significant sum.

With respect to condition (3), if the reinsurance arrangements are such that the Commissioner cannot affirmatively determine they pose no undue risk, the arrangements could cause or contribute to a licensee's financial hazard or insolvency, to the detriment of the insurer, its policyholders and creditors.

The definition is reasonably necessary to specify the manner in which the Commissioner will apply the "material deficiency" standard.

§2303.2(v) "Regulatory oversight" is defined as the exercise of any or all powers granted a regulator to monitor or control the operations of an insurer; oversight may be formal, informal or voluntary. The term is limited to actions taken by a regulator in response to the condition of an insurer that the regulator determines may be hazardous to the insurer, its policyholders and creditors. The definition specifies that regulatory oversight may be preliminary in nature, such as a determination to include a licensee on a regulator's watch list.

Most regulatory oversight by the Department occurs informally, wherein the Department closely monitors licensees whose financial condition the Commissioner has determined may be hazardous. Informal monitoring usually includes frequent conferences with the licensee and more frequent financial reporting by the licensee than generally required. Informal monitoring may include the assignment of an examiner to provide oversight at the insurer's premises. Oversight may also include activities such as working with a licensee to obtain quick regulatory approval of new reinsurance arrangements or persuading a parent company to provide additional capital.

The definition is reasonably necessary to specify that "regulatory oversight" as used in the regulations has a meaning more broad than the formal proceedings often associated with the term, such as the issuing of a Cease and Desist Order or an Order of Conservation, Liquidation or Rehabilitation.

§2303.2(z) A "volume insurer" is defined as a foreign insurer whose California business represents specified percentages of its total business, or whose direct written premium in California exceeds $20 Million, or which assumes 50% or more of its total premium, as reported on its most recent annual statement. Various regulations are limited in application to volume insurers, in order to reduce the compliance burden on licensees as well as to reduce the oversight burden on the Department. It is reasonably necessary to limit the application of certain regulations to volume insurers in order to permit the Department to focus its scarce resources on those insurers whose failure may have a significant adverse impact upon California consumers. Licensees that are primarily reinsurers are included in the class of volume insurers, in that while they may have minimal or no direct written premium in California, their failure could cause a significant adverse impact upon California consumers through business assumed from other licensed insurers. This definition is reasonably necessary to specify those licensees that are subject to a particular regulation.

§2303.3 CREDIT FOR REINSURANCE CEDED TO ADMITTED INSURER

This section clarifies, interprets and implements Code Sections 922.4(a) and 922.6(b) and notifies licensees that they may claim credit on their financial statements for reinsurance ceded to an assuming insurer that is licensed in California. Although this section is based upon the Model Regulation, it expands upon the Model Regulation for purposes of efficiency in enforcement and compliance with California law.

The Model Regulation and the Code are organized in a manner that separates the credit for reinsurance requirements applicable to domestic and foreign insurers. (Credit on financial

statements for reinsurance is also referred to as "credit for reinsurance" or "statement credit".) The Code generally follows the format of the NAIC Model Law on Credit for Reinsurance, placing requirements for domestic and foreign insurers in separate sections. Code Section 922.4(a) and the corresponding section of the Model Regulation permit *domestic* insurers to claim statement credit for cessions to licensed insurers. Code Section 922.6(b) provides that a *foreign* insurer may be disallowed credit for reinsurance to an assuming insurer, if a domestic insurer could not claim statement credit for a cession to that same assuming insurer. Therefore, since a domestic insurer may claim statement credit for a cession to a licensed insurer, a foreign insurer could also claim statement credit for a cession to that same licensed insurer.

Since the Code permits both domestic insurers and foreign insurers to claim statement credit for cessions to licensed insurers, albeit under two different Code Sections, the regulation permits all licensed insurers, whether domestic or foreign, to claim statement credit for cessions to licensed insurers. Applying the section to all licensees is reasonably necessary to provide a clearer statement of the law and to simplify both compliance and enforcement.

The section contains conditions for statement credit that are not included in the Model Regulation. The conditions are necessary so that the regulations conform to California law. The conditions and the justification for each are as follows:

(1) Credit for reinsurance is not permitted if the assuming insurer is the subject of a regulatory order or regulatory oversight on the grounds of hazardous financial condition by any state in which it is licensed.

This condition is necessary to comply with California law. Code Section 922.4(a) does not permit credit for reinsurance if the assuming insurer is the subject of a regulatory order or oversight on the grounds of hazardous financial condition by any state in which it is licensed.

(2) Credit for reinsurance is not permitted if the cession is not in compliance with the applicable provisions of Sections 2303.11 through 2303.13 of the regulations.

This condition is necessary to comply with California law, as follows:

Pursuant to Code Section 922.2, credit for reinsurance is not permitted unless the reinsurance agreement meets certain requirements. These requirements are clarified and interpreted in Section 2303.13.

Pursuant to Code Section 922.3, credit for reinsurance is not permitted unless "the reinsurer undertakes to indemnify the ceding insurer, not only in form but in fact, against all or a part of the loss or liability arising out of the original insurance." This requirement is known as "risk transfer", and is clarified and interpreted in Sections 2303.11 and 2303.12.

Pursuant to Code Section 923, licensees must comply with those provisions of the NAIC Accounting Guidance that do not conflict with the Code. Requirements from the NAIC Accounting Guidance relating to credit for reinsurance are specified, clarified and interpreted in Section 2303.13.

(3) Credit for reinsurance is not permitted if the assuming insurer was not licensed or otherwise permitted to write or assume the lines or classes of business in its state of domicle.

This condition is necessary to conform to California law. Pursuant to Code Section 922.4, credit for reinsurance is not permitted unless the assuming insurer is licensed in its state of domicile for the classes or lines of business assumed.

The conditions of this section are reasonably necessary in order to provide a clear, concise and comprehensive statement of the applicable requirements for statement credit.

The section also includes a requirement that a licensee must notify the Commissioner within five (5) days of learning that it is the subject of a regulatory order or regulatory oversight by any state in which it is licensed concerning a hazardous financial condition. If the regulatory action is confidential, disclosure to the Commissioner is required only if permitted by the regulator issuing the order or initiating the oversight.

Since statement credit is not permitted for cessions to a licensee that is the subject of a regulatory order or oversight, the regulatory action will impact all of the licensee's ceding insurers. A ceding insurer's loss of credit for reinsurance will decrease its surplus and may affect its operating ratios and rating strength. Depending upon the relative size of the cession, a ceding insurer may be adversely affected by the loss of statement credit to the point of financial hazard or insolvency, requiring heightened oversight by the Commissioner and perhaps immediate regulatory action.

Although the Commissioner may eventually receive notice of the regulatory action taken against the licensee through official channels, the quickest and most efficient manner to obtain such notice is directly from the affected licensee. The notice requirement is not burdensome to a licensee and is reasonably necessary to enable the Commissioner to quickly respond if he determines that heightened oversight or other regulatory action is necessary.

§2303.4 CREDIT FOR REINSURANCE CEDED TO ACCREDITED REINSURER

This section provides notice to licensees that they may claim credit on their financial statements for reinsurance ceded to an assuming insurer that has been approved as an accredited reinsurer in California. The section specifies the requirements for an insurer not licensed in California to become accredited and the requirements to maintain accreditation. Although this section is based upon the Model Regulation, it expands upon the Model

Regulation for purposes of clarity, efficiency in enforcement, and compliance with California law.

§2303.4(a) This subdivision clarifies, interprets and implements Code Sections 922.4(b) and 922.6(b) and permits a licensed insurer to claim credit on its financial statements for reinsurance ceded to an assuming insurer that is an accredited reinsurer in California. Although this subdivision is based upon the Model Regulation, it expands upon the Model Regulation for purposes of clarity, efficiency in enforcement, and compliance with California law.

The Model Regulation and the Code are organized in a manner that separates the credit for reinsurance requirements applicable to domestic and foreign insurers. (Credit on financial statements for reinsurance is also referred to as "credit for reinsurance" or "statement credit".) The Code follows the format of the NAIC Model Law on Credit for Reinsurance, placing requirements for domestic and foreign insurers in separate sections. Code Section 922.4(b) and the corresponding section of the Model Regulation permit *domestic* insurers to claim statement credit for cessions to accredited reinsurers. Code Section 922.6(b) provides that a *foreign* insurer may be disallowed credit for reinsurance to an assuming insurer, if a domestic insurer could not claim statement credit for a cession to that same assuming insurer. Therefore, since a domestic insurer may claim statement credit for a cession to an accredited reinsurer, a foreign insurer could also claim statement credit for a cession to that same accredited reinsurer.

Since the Code permits both domestic insurers and foreign insurers to claim statement credit for cessions to accredited reinsurers, albeit under two different Code Sections, the subdivision is reasonably necessary to notify all licensed insurers, whether domestic or foreign, that they may claim statement credit for cessions to accredited reinsurers. Applying the subdivision to all licensees is reasonably necessary to provide a clearer statement of the law and to simplify both compliance and enforcement.

This subdivision contains conditions for statement credit that are not included in the Model Regulation. The conditions are necessary so that the regulations conform to California law. The conditions and the justification for each are as follows:

(1) Credit for reinsurance is not permitted if the assuming insurer is the subject of a regulatory order or regulatory oversight on the grounds of hazardous financial condition by any state in which it is licensed.

This condition is necessary to comply with California law. Code Section 922.4(b) does not permit credit for reinsurance if the assuming insurer is the subject of a regulatory order or oversight on the grounds of hazardous financial condition by any state in which it is licensed.

(2) Credit for reinsurance is not permitted if the cession is not in compliance with the applicable provisions of Sections 2303.11 through 2303.13 of the regulations.

This condition is necessary to comply with California law, as follows:

Pursuant to Code Section 922.2, credit for reinsurance is not permitted unless the reinsurance agreement meets certain requirements. These requirements are clarified and interpreted in Section 2303.13.

Pursuant to Code Section 922.3, credit for reinsurance is not permitted unless "the reinsurer undertakes to indemnify the ceding insurer, not only in form but in fact, against all or a part of the loss or liability arising out of the original insurance." This requirement is known as "risk transfer", and is clarified and interpreted in Sections 2303.11 and 2303.12.

Pursuant to Code Section 923, licensees must comply with those provisions of the NAIC Accounting Guidance that do not conflict with the Code. Requirements from the NAIC Accounting Guidance relating to credit for reinsurance are specified, clarified and interpreted in Section 2303.13.

(3) Credit for reinsurance is not permitted if the assuming insurer was not licensed or otherwise permitted to write or assume the lines or classes of business in its state of domicile.

This condition is necessary to conform to California law. Pursuant to Code Section 922.4, credit for reinsurance is not permitted unless the assuming insurer is licensed in its state of domicile for the classes or lines of business assumed.

The conditions of this subdivision are reasonably necessary to provide a clear, concise and comprehensive statement of the applicable requirements for statement credit.

The subdivision also includes a requirement that an accredited reinsurer must notify the Commissioner within five (5) days of learning that it is the subject of a regulatory order or regulatory oversight by any state in which it is licensed concerning a hazardous financial condition. If the regulatory action is confidential, disclosure to the Commissioner is required only if permitted by the regulator issuing the order or initiating the oversight.

Since statement credit is not permitted for cessions to an accredited reinsurer that is the subject of a regulatory order or oversight, the regulatory action will impact all of the accredited reinsurer's ceding insurers. A ceding insurer's loss of credit for reinsurance will decrease its surplus and may affect its operating ratios and rating strength. Depending upon the relative size of the cession, a ceding insurer may be adversely affected by the loss of statement credit to the point of financial hazard or insolvency, requiring heightened oversight by the Commissioner and perhaps immediate regulatory action.

Although the Commissioner may eventually receive notice of the regulatory action taken against the accredited reinsurer through official channels, the quickest and most efficient manner to obtain such notice is directly from the affected accredited reinsurer. The notice requirement is not burdensome to the reinsurer and is reasonably necessary to enable the Commissioner to quickly respond if he determines that heightened oversight or other regulatory action is necessary.

This subdivision is reasonably necessary to notify all licensees that they may claim statement credit for cessions to accredited reinsurers, to specify requirements applicable to such cessions, and for the efficient and effective enforcement of Code Section 922.4(c).

§2303.4(b) This subdivision specifies the information that is required to be included with an insurer's application for accreditation. Section 2303.4(b)(1) through (6) specifies commitments and information required or permitted for accreditation by various provisions of Code Section 922.4(b), as follows:

§2303.4(b)(1) This paragraph specifies a required form to be used for compliance with several Code provisions. Pursuant to Code Section 922.4(b)(1)(B), the form requires the insurer to consent to examination by the Commissioner. Pursuant to Code Section 922.4(b)(4), the form commits the insurer to bear the expense of examination. Pursuant to authority granted the Commissioner in Code Section 922.4(b)(1)(E) to request other financial information, the form requires the applicant to attach a list of its California ceding insurers and to commit to update the list quarterly.

A current list of ceding insurers is necessary for both assessment of the applicant's financial condition and regulatory action in the event the insurer's accreditation is revoked. A required form is less burdensome to the insurer in not having to create a document to comply with the requirements. A required form is more efficient for the Department in the review of an application to determine whether statutory requirements have been met. The required form with the specified information is reasonably necessary for the efficient and effective enforcement of Code Section 922.4(b).

§2303.4(b)(2) This paragraph specifies a required form to be used for compliance with two Code provisions. Pursuant to Code Section 922.4(b)(1)(A), the form requires the insurer to submit to California jurisdiction. Pursuant to Code Section 922.4(b)(1)(C), the form requires the insurer to designate the Commissioner or an attorney to serve as its agent for service of process.

The Commissioner has determined that the most efficient means to provide actual notice to the insurer is by the appointment of an agent for service of process, with the Commissioner serving as the agent of last resort. Therefore, the form requires the insurer to designate an attorney to serve as its agent for service of process, and provides that if the agent cannot be served or if the insurer is without a designated agent, service may be made upon the Commissioner. A required form is less burdensome to an insurer in not having to create a document to comply with statutory requirements. A required form is more efficient for the Department in the review of an application to determine whether statutory requirements have

been met. The paragraph clarifies and interprets Code Section 922.4(b) and is reasonably necessary for the efficient and effective enforcement of that Code Section.

§2303.4(b)(3) This paragraph specifies the form of the evidence required by Code Section 922.4(b)(1)(D) to establish that the insurer is licensed to transact insurance in at least one other state. The paragraph requires the evidence of licensure to be in the form of a certified copy. The certification requirement is reasonably necessary to authenticate the evidence of current licensure. The paragraph clarifies and interprets Code Section 922.4(b)(1)(D) and is reasonably necessary for the efficient and effective enforcement of that Code provision.

§2303.4(b)(4) This paragraph requires disclosure by the insurer of whether the insurer or certain affiliates are the subject of any regulatory action and requires the insurer to provide copies of any documents issued by a regulator regarding such action. The paragraph clarifies and interprets the requirements of Code Section 922.4(b)(1)(F) and is reasonably necessary for the efficient and effective enforcement of that Code provision.

§2303.4(b)(5) This paragraph specifies the "other financial information" the Commissioner is permitted to require pursuant to Code Section 922.4(b)(1)(E) in order to assess the qualifications of an applicant for accreditation.

The Commissioner has determined that the financial and regulatory information required in subparagraphs (A) through (G) of this paragraph is necessary to assess the condition of the insurer. The Commissioner has determined that the "news release" information required in subparagraph (H) of this paragraph is reasonably necessary to assess the financial condition of the insurer. Although requesting copies of all news releases issued by or on behalf of the insurer within the year prior to submission may result in the provision of some information not relevant to the insurer's financial condition, the requirement to provide copies of all releases avoids the possibility of selective submission. The information required by this paragraph is reasonably necessary for the efficient and effective enforcement of Code Section 922.4(b).

§2303.4(b)(6) This paragraph specifies that the insurer is to provide additional information or documentation as requested by the Commissioner. Although this paragraph is essentially a restatement of the requirement in Code Section 922.4(b)(1)(E), it is reasonably necessary to include in this subdivision in order to provide a complete checklist for use by insurers submitting applications for accreditation as well as by Department staff reviewing such applications and enforcing this section.

This subdivision is reasonably necessary to notify insurers of the information that is necessary to be included with an application for accreditation, and for the efficient and effective enforcement of Code Section 922.4(b).

§2303.4(c) This subdivision specifies the requirements for an accredited reinsurer to retain eligibility for accreditation. An accredited reinsurer is required to file specified quarterly and annual financial reports at the same time it files those reports with its state of

domicile, to update its list of domestic ceding insurers quarterly, and to file copies of news releases as they are issued (which may be electronic copies). The Commissioner has determined that these filings are reasonably necessary to enable the Department to monitor the financial condition of the insurer.

Not later than August 15th of each year, an accredited reinsurer is required to file all documents required on the initial application, except that it is not necessary to file duplicates of financial documents already submitted. This filing is reasonably necessary to enable the Department to assess the continued financial condition of the insurer and to confirm that it continues to meet the standards for accreditation. This subdivision is reasonably necessary to notify affected persons of the requirements for continuing accreditation, as well as for the efficient and effective enforcement of Code Section 922.4(b).

§2303.4(d) This subdivision specifies that the reinsurer shall be charged for the expenses of examination as required by Code Section 922.4(b)(4). The section provides that the application for accreditation and subsequent filings shall be submitted in the manner prescribed in Section 2303.22. This subdivision is reasonably necessary to notify affected persons of accreditation requirements, as well as for the efficient and effective enforcement of Code Section 922.4(b).

§2303.4(e) This subdivision provides notice that an accredited insurer is not a licensed insurer in California and may not solicit or transact insurance business in this state either directly or through an agent or reinsurance intermediary acting on its behalf.

In insurance regulatory law, there is a major distinction between companies that have been "admitted" or licensed in California and those which have not. When a company is approved for admission, it is issued a Certificate of Authority (a "license") that permits the company to transact insurance business in California. The Commissioner has jurisdiction over admitted companies which gives him the rights to, *inter alia*, to examine their books, to require a certain level of solvency, to specify claims handling requirements, and to specify requirements for various financial transactions.

However, an accredited insurer is not admitted, and the Commissioner has no jurisdiction over it. If the reinsurer commits an act of which the Commissioner disapproves (e.g., refusing to make payment when due), he can seek the company's removal from the list of accredited reinsurers, but he cannot require the company to change its conduct.

The accreditation procedure established by Code Section 922.4(c) is not a substitute for licensing. Only licensed companies may transact or solicit insurance business in California. (*See* Code Sections 35 and 700(a).) Indeed, the unlawful transaction or solicitation of insurance is a felony. (Code Section 700(b).)

Prior to 1997, when a reinsurer not licensed in California assumed business from a California licensed company, the Code did not permit the ceding company to claim statement credit for the cession, unless the non-admitted reinsurer provided specified "security" to guarantee that

it would pay the reinsurance when due. In 1996 the Code was amended to permit statement credit for cessions to accredited reinsurers without the requirement for specific security.

The accreditation statute (Code Section 922.4(b)) does not confer any rights upon the accredited reinsurer. There is no intent, express or implied, to permit an accredited insurer to transact insurance in California, which is a privilege reserved to licensees. Accredited reinsurers are listed on the Department's public website. Licensed insurers or their agents may solicit such reinsurers, but not vice versa. An accredited insurer desiring to solicit business in California must become licensed.

An accredited insurer is permitted only to *accept* California business that has been offered to it by a California licensed agent or an admitted company. Appearing on the Department's list of accredited reinsurers merely notifies licensed agents and admitted insurers that although the listed company is not admitted, the Department has determined that it meets California standards for accredited reinsurers *this year*. (An accredited insurer must re-qualify annually.)

This subdivision interprets and clarifies Code Sections 35, 700(a) and 922.4(b), and is reasonably necessary to notify affected persons of the limitations of accreditation.

§2303.5 CREDIT FOR REINSURANCE SECURED BY AN APPROVED U.S. TRUST

This section provides notice to licensees that they may claim credit on their financial statements for reinsurance ceded to an insurer not licensed in California that maintains an approved U.S. trust for payment of the valid claims of its U.S. domiciled ceding insurers. The section states the requirements for an eligible U.S. trust and specifies the procedures to obtain and maintain approval. Although this section is based upon the Model Regulation, it expands upon the Model Regulation for purposes of clarity, efficiency in enforcement, and compliance with California law.

§2303.5(a) This subdivision clarifies, interprets and implements Code Sections 922.4(b) and 922.6(b) and notifies licensed insurers that they may claim credit on their financial statements for reinsurance ceded to an assuming insurer that maintains an approved U.S. trust for payment of the valid claims of its U.S. domiciled ceding insurers. Although this subdivision is based upon the Model Regulation, it expands upon the Model Regulation for purposes of clarity, efficiency in enforcement, and compliance with California law.

The Model Regulation and the Code are organized in a manner that separates the credit for reinsurance requirements applicable to domestic and foreign insurers. (Credit on financial statements for reinsurance is also referred to as "credit for reinsurance" or "statement credit".) The Code follows the format of the NAIC Model Law on Credit for Reinsurance, placing requirements for domestic and foreign insurers in separate sections. Code Section 922.4(c) and the corresponding section of the Model Regulation permit *domestic* insurers to claim statement credit for cessions to insurers with approved U.S. trusts. Code Section 922.6(b) provides that a *foreign* insurer may be disallowed credit for reinsurance to an

assuming insurer, if a domestic insurer could not claim statement credit for a cession to that same assuming insurer. Therefore, since a domestic insurer may claim statement credit for a cession to an insurer with an approved U.S. trust, a foreign insurer could also claim statement credit for a cession to that same insurer.

Since the Code permits both domestic insurers and foreign insurers to claim statement credit for cessions to insurers with an approved U.S. trust, albeit under two different Code Sections, this subdivision is reasonably necessary to provide notice to all licensed insurers, whether domestic or foreign, that they may claim statement credit for cessions to insurers with approved U.S. trusts. Applying the subdivision to all licensees is reasonably necessary to provide a more clear statement of the law and to simplify both compliance and enforcement.

The subdivision specifies that credit will not be permitted unless the reinsurance agreement meets the applicable requirements of Sections 2303.11 through 2303.13 of the regulations. This condition is necessary to comply with California law, as follows:

> Pursuant to Code Section 922.2, credit for reinsurance is not permitted unless the reinsurance agreement meets certain requirements. These requirements are clarified and interpreted in Section 2303.13.
>
> Pursuant to Code Section 922.3, credit for reinsurance is not permitted unless "the reinsurer undertakes to indemnify the ceding insurer, not only in form but in fact, against all or a part of the loss or liability arising out of the original insurance." This requirement is known as "risk transfer", and is clarified and interpreted in Sections 2303.11 and 2303.12.
>
> Pursuant to Code Section 923, licensees must comply with those provisions of the NAIC Accounting Guidance that do not conflict with the Code. Requirements from the NAIC Accounting Guidance relating to credit for reinsurance are specified, clarified and interpreted in Section 2303.13.

The subdivision defines "assuming insurer" as used in the section as including all the categories of insurers described in Code Section 922.4(c)(4). That Code section sets different financial levels for funding U.S. trusts, depending upon whether a single insurer or a group of insurers or a group of underwriters establishes the trust. This definition is reasonably necessary to notify all such entities that the U.S. trusts they establish must meet the requirements of this section in order to be approved by the Commissioner.

This subdivision is reasonably necessary to notify all licensees that they may claim statement credit for cessions to an assuming insurer maintaining an approved trust, to specify requirements applicable to such cessions, to notify all entities that establish U.S. trusts of the applicability of this section, and to efficiently and effectively enforce Code Section 922.4(c).

§2303.5(b) This subdivision specifies the documents that are required to be included with an insurer's application for approval of a U.S. Trust, as follows:

§2303.5(b)(1) This paragraph requires a copy of the trust document, certified by the commissioner of the state that has the principal oversight of the trust. A copy of the trust document is necessary for the Commissioner to make a determination that the form of the trust meets statutory requirements. A certified copy of the trust document is reasonably necessary for purposes of authentication.

§2303.5(b)(2) This paragraph requires a copy of the approval of the form of the trust issued by the commissioner of the principal oversight state. A copy of the approval is necessary to make a determination that the trust meets the requirements of Code Section 922.4(c)(2), which requires approval of the form of the trust by the commissioner of the principal oversight state. A certified copy of the approval issued is reasonably necessary for purposes of authentication.

§2303.5(b)(3) This paragraph requires a copy of an independent audit report of the trust. The Commissioner has determined that a copy of the independent audit report is necessary to make a determination of the sufficiency of the trust.

§2303.5(b)(4) This paragraph requires an actuarial opinion. The Commissioner has determined that a copy of an actuarial opinion is necessary to make a determination of the sufficiency of the trust.

§2303.5(b)(5) This paragraph requires copies of all documents submitted to the oversight state, unless the Commissioner has agreed that specified documents need not be provided. The Commissioner has determined that copies of the financial documents submitted to the oversight state are necessary to make a determination of the sufficiency of the trust.

§2303.5(b)(6) This paragraph specifies a required form to be used for compliance with several Code provisions. Pursuant to Code Section 922.4(c)(3)(c), the form requires the insurer to consent to examination by the Commissioner. Pursuant to Code Section 922.4(c)(5), the form commits the insurer to bear the expense of examination. Pursuant to Code Section 922.4(c)(1) requiring information reported in the annual statement, the form follows the Model Regulation in requiring the applicant to attach a list of its California ceding insurers and to commit to update the list quarterly. A current list of ceding insurers is reasonably necessary for both assessment of the applicant's financial condition, as well as regulatory action in the event that approval of the trust is revoked. A required form is less burdensome to the insurer by not having to create a document to comply with the requirements. A required form is more efficient for the Department in the review of an application to determine whether statutory requirements have been met. The required form with the specified information is reasonably necessary for the efficient and effective enforcement of Code Section 922.4(c).

§2303.5(b)(7) This paragraph specifies a required form to be used for compliance with Code Section 922.4(e) that requires the insurer to submit to California jurisdiction and appoint an agent for service of process. Code Section 922.4(e)((2) requires the insurer to designate the Commissioner or an attorney to serve as its agent for service of

process. The Commissioner has determined that the most efficient means to provide actual notice to the insurer is by the insurer's appointment of an agent for service of process, with the Commissioner serving as the agent of last resort. Therefore, the form requires the insurer to designate an attorney to serve as its agent for service of process, and provides that if the agent cannot be served or if the insurer is without a designated agent, service may be made upon the Commissioner. A required form is less burdensome to an insurer by not having to create a document to comply with statutory requirements. A required form is more efficient for the Department in the review of an application to determine whether statutory requirements have been met. The paragraph clarifies and interprets Code Section 922.4(c) and is reasonably necessary for the efficient and effective enforcement of that Code Section.

§2303.5(b)(8) This paragraph specifies that the insurer is required to provide additional information or documentation as requested by the Commissioner. The Commissioner has determined that occasions may arise where additional information may be necessary in order to assess the sufficiency of a U.S. trust. This requirement is reasonably necessary for the efficient and effective review in determining whether a trust meets statutory requirements.

This subdivision is reasonably necessary to notify insurers of the information that the Commissioner has determined is necessary to be included in an application for approval of a U.S. trust, and for the efficient and effective enforcement of Code Section 922.4(b).

§2303.5(c) This subdivision prescribes the requirements for an acceptable form of the trust document. It requires the form to comply with Code Sections 922.4(c)(3) and 922.4(f) as well as the requirements of subdivision (f) of this section, if the assets of the trust include a letter of credit. The letter of credit requirements in subdivision (f) are requirements in the Model Regulation. Although these requirements may be duplicative, they are reasonably necessary to include in this subdivision in order to provide one comprehensive checklist for both the efficient preparation of the trust form and the efficient review of the trust form to determine acceptability. The subdivision also requires the form of the trust to hold the trustee liable for its own negligence or willful misconduct. This requirement is in the Model Regulation and is reasonably necessary to safeguard trust assets and for uniformity with the requirements of those states that have adopted the Model Regulation.

§2303.5(d) This subdivision prescribes the standards to determine the sufficiency of the trust. It requires the trust to meet specified Code sections and requires the assets to meet the requirements of this section. Although these requirements may be duplicative, they are reasonably necessary to include in this subdivision in order to provide one comprehensive checklist for efficiency in assessing the sufficiency of the trust.

This subdivision specifies that assets equal to liabilities shall be on deposit within 45 days of the end of each calendar quarter, unless the Commissioner determines that a reasonable extension of time should be granted. The 45-day requirement corresponds to the time period in which insurers are required to file financial statements at the end of each quarter. In the preparation of those financial statements the insurer will learn whether the assets on deposit in the trust are sufficient to equal the liabilities it will report on its financial statements. If

the trust deposit is insufficient, the insurer is required to deposit funds in an amount sufficient to equal its liabilities, in order to comply with the requirements of Code Section 922.4(c)(4). Upon a showing of good cause, the Commissioner may grant an extension of time to make the additional deposit. This requirement is reasonably necessary to establish the procedures to maintain an approved U.S. trust at the level required by the Code.

This subdivision also specifies the type of assets permitted to fund the trust. Permitted assets include cash, qualified Certificates of Deposit, investments permitted by subdivision (e) of this section, and letters of credit as permitted in subdivision (f) of this section. These requirements are all found in the Model Regulation. Although a restatement of these requirements may be duplicative, they are reasonably necessary to include in this subdivision in order to provide one comprehensive checklist for efficiency in both funding the trust and assessing its sufficiency.

§2303.5(e) This subdivision specifies those investments that may be considered in assessing the sufficiency of the trust. These requirements are a virtual copy of the corresponding sections in the Model Regulation, except for revisions in formatting and numbering for clarity. These requirements are reasonably necessary both to ensure that the trust is funded with quality investments, and for uniformity among the states that have adopted the Model Regulation.

§2303.5(f) This subdivision specifies the requirements for a letter of credit to qualify as an asset of the trust. The subdivision provides that a letter of credit may not exceed 20% of the assets of the trust. The 20% limitation is reasonably necessary to reduce the inherent risk in concentration of assets. The trust agreement requirements are a virtual copy of the corresponding section of the Model Regulation, except for revisions in formatting and numbering for clarity. The trust agreement requirements are reasonably necessary for uniformity among the states that have adopted the Model Regulation.

§2303.5(g) This subdivision specifies the liabilities to be covered by the trust. This requirement is a virtual copy of the corresponding section of the Model Regulation, except for revisions in formatting and numbering for clarity, and a change in a term to conform to California law. The Model uses the term "accident and health" and "health" in categorizing liabilities, however, Code Section 106 uses the term "disability" for such business. This requirement is reasonably necessary for uniformity among the states that have adopted the Model Regulation.

§2303.5(h) This subdivision provides that separate security provided for a specific liability must be exhausted prior to making a claim on the trust for that liability. This requirement is a virtual copy of the corresponding section of the Model Regulation, except for revisions in formatting and numbering for clarity. This requirement is reasonably necessary for uniformity among the states that have adopted the Model Regulation.

§2303.5(i) This subdivision specifies the requirements to maintain eligibility for the trust. An assuming insurer maintaining an approved U.S. trust is required to file specified quarterly and annual financial reports at the same time it files those reports with its oversight state, and

to update its list of domestic ceding insurers quarterly. These filings are reasonably necessary to enable the Department to monitor the financial condition of the trust. The subdivision provides that not later than August 15th of each year, an assuming insurer maintaining an approved U.S. trust is required to file all documents required on the initial application, except that it is not necessary to file duplicates of financial documents already submitted. This filing is reasonably necessary to assess the continued financial condition of the trust and to confirm that it continues to meet the standards for approval. This subdivision is reasonably necessary to notify affected persons of the requirements for continuing eligibility as an approved U.S. trust, as well as for the efficient and effective enforcement of Code Section 922.4(b).

§2303.5(j) This subdivision requires the assuming insurer maintaining the trust to bear all costs of examination as required by Code Section 922.4(c)(5). Although a restatement of this requirement may be duplicative, it is reasonably necessary to include in this subdivision in order to provide one comprehensive checklist for requirements applicable to approved U.S. trusts.

§2303.5(k) This subdivision provides notice that an assuming insurer with an approved U.S. trust is not a licensed insurer in California and may not solicit or transact insurance business in this state either directly or through an agent or reinsurance intermediary acting on its behalf.

In insurance regulatory law, there is a major distinction between companies that have been "admitted" or licensed in California and those which have not. When a company is approved for admission pursuant to Code Section 717, it is issued a Certificate of Authority (a "license") that permits the company to transact insurance business in California. The Commissioner has jurisdiction over admitted companies which gives him the right to, *inter alia*, examine their books, require a certain level of solvency, specify claims handling requirements, and specify requirements for various financial transactions.

However, a reinsurer with an approved U.S. trust is not admitted, and the Commissioner has no jurisdiction over it. If the reinsurer commits an act of which the Commissioner disapproves (e.g., denying to make payment when due), he can seek the company's removal from the list of reinsurers with an approved U.S. trust, but he cannot require the company to change its conduct.

The trust approval procedure established by Code Section 922.4(c) is not a substitute for licensing. Only licensed companies may transact or solicit insurance business in California. (*See* Code Sections 35 and 700(a).) Indeed, the unlawful transaction or solicitation of insurance is a felony. (Code Section 700(b).)

Prior to 1997, when a reinsurer not licensed in California assumed business from a California licensed company, the Code did not permit the ceding company to claim statement credit for the cession, unless the non-admitted reinsurer provided specified "security" to guarantee that it would pay the reinsurance when due. In 1996 the Code was amended to permit statement

credit for cessions to reinsurers that maintained approved U.S. trusts without the requirement for specific security.

The trust approval statute (Code Section 922.4(c)) does not confer any rights upon the reinsurer maintaining the trust. There is no intent, express or implied, to permit a reinsurer maintaining an approved U.S. trust to transact insurance in California, which is a privilege reserved to licensees. Reinsurers with approved U.S. trusts are listed on the Department's public website. Licensed insurers or their agents may solicit such reinsurers, but not vice versa. Reinsurers with U.S. trusts desiring to solicit business in California must become licensed.

A reinsurer with an approved U.S. trust is permitted only to *accept* California business that has been offered to it by a California licensed agent or an admitted company. Appearing on the Department's list of approved U.S. trusts merely notifies licensed agents and admitted insurers that although the listed company is not admitted, the Department has performed an examination of the U.S. trust maintained by the reinsurer and the trust meets California standards for such trusts *this year*. (The reinsurer with the U.S. trust must re-qualify annually.)

This subdivision interprets and clarifies Code Sections 35, 700(a), 717 and 922.4(c), and is reasonably necessary to notify affected persons of the limitations on reinsurers maintaining approved U.S. trusts.

§2303.6 CREDIT FOR REINSURANCE REQUIRED BY LAW

This section interprets the word "jurisdiction" as used in Code Section 922.4(d) as meaning a state, district or territory of the United States. That Code section requires the Commissioner to allow credit on financial statements of licensees for reinsurance if the reinsurance is required by the laws of another jurisdiction, such as a state pool of reinsurers to cover certain types of losses. This definition is reasonably necessary to ensure that required credit for reinsurance is permitted only for jurisdictions that have standards reasonably similar to California standards.

§2303.7 CREDIT FOR REINSURANCE SECURED BY A SINGLE BENEFICIARY TRUST

Code Section 922.5 permits a domestic insurer to claim credit on its financial statements for a cession to an unauthorized reinsurer if the reinsurer provides specified collateral to guarantee its obligations under the reinsurance agreement. This section interprets and implements Code Section 922.5(a)(2) that permits the collateral to be in the form of a single beneficiary trust. Except as noted in this section, the regulation is a virtual copy of the Model Regulation, except for non-substantive changes in language, formatting and numbering, for both clarity and style.

§2303.7(a) This subdivision specifies requirements applicable to domestic insurers claiming credit on their financial statements for cessions secured by a single beneficiary trust,

and provides that the amount of the credit shall not exceed the liabilities carried by the ceding insurer.

The subdivision expands upon the Model Regulation by specifying that credit will not be permitted unless the cession meets the applicable requirements of Sections 2303.11 through 2303.13 of the regulations. This condition is necessary to comply with California law, as follows:

> Pursuant to Code Section 922.2, credit for reinsurance is not permitted unless the reinsurance agreement meets certain requirements. These requirements are clarified and interpreted in Section 2303.13.
>
> Pursuant to Code Section 922.3, credit for reinsurance is not permitted unless "the reinsurer undertakes to indemnify the ceding insurer, not only in form but in fact, against all or a part of the loss or liability arising out of the original insurance." This requirement is known as "risk transfer", and is clarified and interpreted in Sections 2303.11 and 2303.12.
>
> Pursuant to Code Section 923, licensees must comply with those provisions of the NAIC Accounting Guidance that do not conflict with the Code. Requirements from the NAIC Accounting Guidance relating to credit for reinsurance are specified, clarified and interpreted in Section 2303.13.

This subdivision is reasonably necessary to interpret and implement Code Section 922.5(a)(2), to notify affected persons of requirements applicable to reinsurance agreements secured by trust, to promote uniformity of standards among the different states to the extent possible under California law, and for the efficient and effective enforcement of Code Section 922.5(2).

§2303.7(b) This subdivision defines terms used throughout the section, "beneficiary (the ceding insurer)," "grantor (the reinsurer)," and "trustee (the qualified bank)". The definitions are reasonably necessary to inform affected persons of the specific meaning of the words as used in the section, as well as to achieve uniformity among the states that have adopted the Model Regulation.

§2303.7(c) This subdivision specifies the requirements for a trust acceptable to the Commissioner, including requirements for the form of the trust agreement. The requirements follow the Model Regulation. The subdivision is reasonably necessary to inform affected persons of the requirements for a trust acceptable to the Commissioner, as well as to achieve uniformity among the states that have adopted the Model Regulation.

§2303.7(d) This subdivision specifies optional provisions that may be included within the trust agreement. With one exception, this subdivision follows the Model Regulation.

The exception concerns a "conditional use" provision that may be included within the trust agreement. Code Section 922.5(a)(2) requires that only the ceding insurer may draw funds

from the trust. The mandatory provisions of the Model Regulation (covered in Section 2303.7(c)) require the trustee to pay the ceding insurer "on demand", without condition and without prior notice to the reinsurer. However, the Model Regulation includes an optional provision that prescribes conditions for the ceding insurer's use of the trust funds, e.g., the ceding insurer will draw trust funds only when the reinsurer has not made payments due. The presence of the conditional use provision in the trust agreement would create a potential conflict for the trustee if it is notified by the reinsurer that the ceding insurer is "not entitled" to draw funds from the trust. The trustee might deposit the funds in court rather than pay the ceding insurer, causing the ceding insurer to suffer delay and litigation expense to obtain the funds.

Code Section 922.5 provides for three types of collateral to secure reinsurance assumed by an unauthorized reinsurer: (1) cash held by the ceding insurer under a funds held reinsurance agreement (see Section 2303.9), (2) a letter of credit which can be drawn upon solely by the ceding insurer without condition (see Section 2303.8), and (3) funds held in a trust subject to withdrawal solely by the ceding insurer. The first option for collateral, a funds held reinsurance agreement, provides actual cash to be held by the ceding insurer. The second option, a letter of credit, is tantamount to cash. It would be consistent to interpret the statute as requiring that the third option, a trust, also be in a form tantamount to cash, which would preclude a conditional use provision in the trust agreement. Therefore, the conditional use provision is not included as an option for the trust agreement. Instead, it has been made an option for the reinsurance agreement secured by the trust (see Section 2303.7(f)).

The subdivision is reasonably necessary to inform affected persons of the optional requirements for a trust acceptable to the Commissioner, as well as to promote uniformity of standards among the different states to the extent possible under California law.

§2303.7(e) This subdivision states the requirements that must be included within the reinsurance agreement of a domestic ceding insurer with an unauthorized reinsurer that is secured by a trust. The requirements generally follow the Model Regulation. However, in several instances, the Model Regulation requires provisions to be included in either the trust agreement or the reinsurance agreement. The Commissioner has determined that the trust agreement should contain only those requirements absolutely necessary, to better preserve its status as "tantamount to cash" in order to comply with Code Section 922.5(a) as discussed above in Section 2303.7(d) of this document. Therefore, the Commissioner has included such required provisions within the reinsurance agreement. For example, the Model Regulation permits the requirement that assets placed in the trust that consist of investments in affiliates shall not exceed 5% of the total investments. Since the trustee has no role in determining acceptable trust assets, and the terms of the reinsurance agreement set the requirements for funding the trust, this requirement is not necessary for the trust agreement and has been made mandatory for the reinsurance agreement.

The subdivision is reasonably necessary to inform affected persons of the requirements established by the Commissioner for a reinsurance agreement which is to be secured by a single beneficiary trust, as well as to promote uniformity of standards among the different states to the extent possible under California law.

§2303.7(f) This subdivision states the optional provisions that may be included within the reinsurance agreement of a domestic ceding insurer with an unauthorized reinsurer that is secured by a trust. The optional requirements generally follow the Model Regulation, except that the conditional use provision discussed in Section 2303.7(d) of this document is included in this section. The subdivision is reasonably necessary to inform affected persons of optional provisions which may be included in a reinsurance agreement of a domestic insurer which is to be secured by a single beneficiary trust, as well as to achieve uniformity among the states that have adopted the Model Regulation so far as is possible under California law.

§2303.7(g) This subdivision concerns financial reporting and notifies domestic insurers of the limitations on claiming statement for reinsurance secured by a single beneficiary trust. The language is copied from the Model Regulation. The subdivision is reasonably necessary to inform domestic insurers of proper accounting procedures and to achieve uniformity among the states that have adopted this provision of the Model Regulation.

§2303.7(h) This subdivision provides that the failure of a trust agreement used to secure reinsurance to specifically identify the beneficiary shall not be construed to limit actions the Commissioner is permitted to take regarding the trust. The language is copied from the Model Regulation. The subdivision is reasonably necessary to inform affected parties of the Commissioner's rights with regard to the trust under specified circumstances, and to achieve uniformity among the states that have adopted this provision of the Model Regulation.

§2303.7(i) The other subdivisions of this section are applicable only to *domestic* insurers. However, this subdivision provides notice to affected persons that credit on a financial statement of a *foreign* insurer shall be allowed for reinsurance ceded to an unauthorized reinsurer and secured by a trust, to the extent that credit is allowed by the foreign insurer's state of domicile, unless the Commissioner has made a determination pursuant to Section 2303.10(d) of these regulations that the transaction does not meet, in substance, the requirements of this section.

This subdivision is reasonably necessary to inform affected persons of the relationship between this section and Section 2303.10, as well as the relationship between the Code sections upon which those sections are based: Code Section 922.5(a)(2) and Code Section 922.6(b). This subdivision is reasonably necessary for the efficient and effective enforcement of Code Section 922.6(b).

§2303.7(j) This subdivision is reasonably necessary in that it informs affected persons that denial of statement credit under this section shall be made in the manner prescribed in Section 2303.19(c) of the regulations. This subdivision is reasonably necessary for the efficient and effective enforcement of Code Section 922.5.

§2303.8 CREDIT FOR REINSURANCE SECURED BY LETTER OF CREDIT

Code Section 922.5 permits a domestic insurer to claim credit on its financial statements for a cession to an unauthorized reinsurer if the reinsurer provides specified collateral to guarantee

its obligations under the reinsurance agreement. This section interprets and implements Code Section 922.5(b) that permits the collateral to be in the form of a letter of credit ("LOC"). Although this section is generally based on the Model Regulation, it includes additional requirements that the Commissioner has determined are necessary to comply with California law and to protect the interests of the domestic ceding insurer, its policyholders and creditors.

§2303.8(a) This subdivision specifies requirements applicable to domestic insurers claiming credit on their financial statements for cessions secured by an LOC, and provides that the amount of the credit shall not exceed the liabilities carried by the ceding insurer.

The subdivision expands upon the Model Regulation by specifying that credit will not be permitted unless the cession meets the applicable requirements of Sections 2303.11 through 2303.13 of the regulations. This condition is necessary to comply with California law, as follows:

> Pursuant to Code Section 922.2, credit for reinsurance is not permitted unless the reinsurance agreement meets certain requirements. These requirements are clarified and interpreted in Section 2303.13.
>
> Pursuant to Code Section 922.3, credit for reinsurance is not permitted unless "the reinsurer undertakes to indemnify the ceding insurer, not only in form but in fact, against all or a part of the loss or liability arising out of the original insurance." This requirement is known as "risk transfer", and is clarified and interpreted in Sections 2303.11 and 2303.12.
>
> Pursuant to Code Section 923, licensees must comply with those provisions of the NAIC Accounting Guidance that do not conflict with the Code. Requirements from the NAIC Accounting Guidance relating to credit for reinsurance are specified, clarified and interpreted in Section 2303.13.

This subdivision is reasonably necessary to notify domestic insurers that they may claim statement credit for cessions secured by an LOC which is satisfactory to the Commissioner, to specify requirements applicable to such cessions, to promote uniformity of standards among the different states to the extent possible under California law, and for the efficient and effective enforcement of Code Section 922.5(2).

This subdivision is reasonably necessary to interpret and implement Code Section 922.5(b), to notify affected persons of requirements applicable to reinsurance agreements secured by letters of credit, to promote uniformity of standards among the different states to the extent possible under California law, and for the efficient and effective enforcement of Code Section 922.5(2).

§2303.8(b) This subdivision uses definitions from the Model Regulation to define terms used throughout the section. The definitions are reasonably necessary to inform affected

persons of the specific meaning of the words as used in the section, as well as to achieve uniformity among the states that have adopted the Model Regulation.

§2303.8(c) This subdivision specifies the requirements for the form of an LOC that would be satisfactory to the Commissioner. Except as noted herein, the requirements generally follow the Model Regulation. The LOC requirements differ from the Model Regulation in the following respects:

(1) Code Section 922.5(b) requires that an LOC be "clean, irrevocable and unconditional". Paragraph (2) of this subdivision requires that an LOC state that it is irrevocable and unconditional. Paragraph (2) (A) of this section gives effect to the word "clean" as used in the Code by containing a requirement that the LOC shall contain no extraneous language or reference to any other agreements, documents or entities. The Model Regulation includes the proscription against "other agreements, documents or entities", but does not mention "extraneous language." The "extraneous language" proscription is reasonably necessary to prevent the inclusion of terms in the LOC that are not specified in this section.

(2) Paragraph 2(B) of this subdivision contains a requirement that except where the LOC is increased, it may not be modified without the prior written consent of the beneficiary (the ceding insurer). This requirement is not included in the Model Regulation. In an insolvency setting, experienced employees of the company may no longer be available, having left the company for secure employment elsewhere. Records may be in disarray as the struggling company lays off record keeping personnel in an attempt to reduce costs in order to continue operations. Unless the issuing bank is required to provide written evidence that the beneficiary consented to a reduction in the amount of the LOC, the company, or the conservator or liquidator, may have no evidence to dispute the claim of reduction. The Commissioner has determined that a requirement for prior written consent for modification of the LOC is minimally burdensome to the affected parties and reasonably necessary for the protection of the domestic ceding insurer, its policyholders and creditors.

(3) Paragraph (6) of this subdivision contains a requirement that sixty (60) days notice is required for a bank to issue an effective notice of its intent to non-renew the LOC. The Model Regulation requires only a 30 day notice period for a non-renewal notice. Such a notice means that at the end of the notice period, the LOC will expire, and the ceding insurer will no longer be able to make a draw upon it. Unless the LOC is replaced by other security meeting the requirements of Code Section 922.5, the ceding insurer will lose the credit it has taken on its financial statements for the reinsurance, which could cause it to be in a condition of financial hazard or insolvency. Upon receipt of a notice of non-renewal, a ceding insurer would contact the reinsurer asking it to provide substitute security and if new security is not timely provided, the ceding insurer would draw down the LOC before it expires.

In the event that the notice of non-renewal is received at a time when the ceding insurer is struggling to avoid insolvency, or is in conservation or liquidation, the

import of a non-renewal notice may be overlooked. In such settings, experienced employees of the company may no longer be available, having left the company for secure employment elsewhere. There may be a shortage of employees to handle routine functions, as the company lays off personnel to reduce operating costs. A notice of non-renewal of an LOC is an out of the ordinary communication, and of a significance that may not be understood by an inexperienced mail handler trying to cover several job functions. The Commissioner has determined that a longer notice period would provide a greater likelihood that the notice would reach a person who understood the significance of the notice before its expiration date.

A longer notice period would also benefit the reinsurer that had obtained the LOC. Prior to expiration of the LOC, the reinsurer is obligated by the reinsurance agreement to provide the ceding insurer with replacement security meeting the requirements of Code Section 922.5. The failure to timely provide replacement security will cause the ceding insurer to draw down the entire LOC, resulting in a loss to the reinsurer of whatever collateral it had provided the bank in consideration for issuing the LOC. As a practical matter, the time to arrange for substitute security is further shortened by the time it takes to receive a mailed notice, and the likelihood that the ceding insurer will not wait until the last day to draw down the LOC. The Commissioner has determined that there will be occasions that a 30-day notice period is too short of a time period for a reinsurer to obtain substitute security, in that frequently, the reason for the bank's non-renewal of the LOC is the changed financial condition of the reinsurer.

The Commissioner has determined that a 30 day notice period is not sufficient in all cases where a notice of non-renewal might be issued. The Commissioner has determined that a requirement for a 60 day notice period is minimally burdensome to the affected parties and reasonably necessary for the protection of the domestic ceding insurer, its policyholders and creditors.

(4) Paragraph (6) of this subdivision includes a requirement that a notice of non-renewal of an LOC must be sent with signature upon delivery required. This requirement is not included in the Model Regulation.

In the event that the notice of non-renewal is received at a time that the ceding insurer is struggling to avoid insolvency, or is in conservation or liquidation, the import of a non-renewal notice or the notice itself may be overlooked. In such settings, experienced employees of the company may no longer be available, having left the company for secure employment elsewhere. There may be a shortage of employees to handle routine functions as staff is laid off to reduce costs. A notice of non-renewal of an LOC is an out of the ordinary communication, and of a significance that may not be understood by an inexperienced mail handler trying to cover several job functions. The requirement to sign for receipt of the notice would give the notice heightened importance, and would provide a greater likelihood that the notice would reach a person who understood its significance.

The Commissioner has determined that a requirement for signature upon delivery of the notice of non-renewal is minimally burdensome to the affected parties and reasonably necessary for the protection of the domestic ceding insurer, its policyholders and creditors.

(5) Paragraph (7) of this subdivision requires the LOC to state that it is subject to and governed by the laws of California, except as otherwise permitted in Section 2303.8(d). The Model Regulation permits, but does not require, an LOC to specify whether it is subject to and governed by the laws of the domiciliary state. However, absent such a requirement, the question of whether an LOC issued to benefit a domestic insurer is subject to and governed by the laws of California would be the subject of litigation. California would be the likely forum for litigation by a California domestic or its liquidation estate, and California law would be more familiar to the court and attorneys involved in such proceedings.

The Commissioner has determined that it is reasonably necessary to require an LOC issued to benefit a domestic insurer to be subject to and governed by California law. Such a requirement will reduce costs by avoiding litigation to determine the governing law, and California law would be more familiar to California courts and attorneys in litigation involving the domestic insurer or its estate. An exception to this requirement is contained in Section 2303.8(d), discussed below.

(6) Paragraphs (9) and (10) of this subdivision extends the expiration date of the LOC to 60 days after the resumption of business if the business of the bank or the beneficiary (the ceding insurer) was interrupted due to specified acts beyond control (e.g., an Act of God, terrorism). The Model Regulation includes the business interruption extension as an optional provision, applicable only to the interruption of the business of the bank and not the beneficiary, and does not specify a period of time for the extension.

The Model Regulation provision pre-dates the events of September 11, 2001. It does not contemplate that perhaps the beneficiary might have been at the bottom of the World Trade Center. The usual extension of time provided in an LOC with this provision is 30 days. However, when a ceding insurer resumes business after such an interruption, which would trigger the running of the 30 day extension period, it may take longer than 30 days to have its records sufficiently organized to be aware of and act upon an LOC about to expire.

The Commissioner has determined that a requirement of a 60 day extension period after a business interruption, and including the interruption of the business of the beneficiary as well as interruption of the business of the bank, is minimally burdensome to the affected parties and reasonably necessary for the protection of the domestic ceding insurer, its policyholders and creditors.

The Commissioner has determined that the letter of credit requirements set forth in this subdivision are reasonably necessary to protect California domestic insurers, their

policyholders and creditors. This subdivision is reasonably necessary to implement Code Section 922.5(b) by providing standards for a letter of credit satisfactory to the Commissioner.

§2303.8(d) This subdivision allows the Commissioner to permit a letter of credit to state that it is subject to and governed by the laws of a state other than California, if the Commissioner has determined that the law on letters of credit in that state is substantially similar to California law from the perspective of a beneficiary, and that the exception to the requirements of Section 2303.8(b)(7) is reasonably necessary to expand the availability of letters of credit to benefit a domestic insurer. It requires the Commissioner to annually publish a list of such states on the Department's public website.

This subdivision is reasonably necessary to allow the Commissioner to permit an exception to the choice of law requirement in those instances where an unauthorized reinsurer is unable to locate a bank willing to issue an LOC governed by California law, and the benefit of the particular reinsurance agreement to the domestic insurer outweighs the preference for California law in proceedings involving the company or its estate.

§2303.8(e) This subdivision provides a blank form letter of credit that meets the requirements of this section and is satisfactory to the Commissioner (found in Section 2303.25(c)). The subdivision also prescribes a procedure to obtain a determination that a particular letter of credit form is satisfactory to the Commissioner. The use of a standard form reduces compliance costs to an insurer, and is more efficient for the Department in a determination of whether a letter of credit meets applicable requirements. This subdivision is reasonably necessary for the efficient and effective implementation of Code Section 922.5(b).

§2303.8(f) This subdivision requires the unauthorized reinsurer providing the letter of credit to consent to California jurisdiction for resolution of disputes arising from the reinsurance agreement and to designate an agent for service of process. This requirement is included in the Model Regulation. The subdivision permits the reinsurer to use an optional form (found in Section 2303.25(b)). If the optional form is not used, this subdivision requires jurisdiction and designation of agent for service of process language to be included within the reinsurance agreement. The jurisdiction and agent for service of process requirements are reasonably necessary to ensure that the domestic insurer can, if necessary, enforce the contract in the most convenient forum.

§2303.8(g) This subdivision states optional provisions that may be included within a reinsurance agreement secured by a letter of credit. The provisions are generally copied from the Model Regulation. Inclusion of the provisions is reasonably necessary to promote uniformity among the states that have adopted the Model Regulation.

§2303.8(h) The other subdivisions of this section are applicable only to *domestic* insurers. However, this subdivision provides notice to affected persons that credit on a financial statement of a *foreign* insurer shall be allowed for reinsurance ceded to an unauthorized reinsurer and secured by a letter of credit, to the extent that credit is allowed by the foreign

insurer's state of domicile, unless the Commissioner has made a determination pursuant to Section 2303.10(d) of these regulations that the transaction does not meet, in substance, the requirements of this section.

This subdivision is reasonably necessary to inform affected persons of the relationship between this section and Section 2303.10, as well as the relationship between the Code sections upon which those sections are based: Code Section 922.5(b) and Code Section 922.6(b). This subdivision is reasonably necessary for the efficient and effective implementation of Code Section 922.6(b).

§2303.8(i) This subdivision is reasonably necessary for the efficient organization of the regulations, in that it specifies that denial of statement credit under this section shall be made in the manner prescribed in Section 2303.19(c) of the regulations. This subdivision is reasonably necessary for the efficient and effective implementation of Code Section 922.5.

§2303.9 CREDIT FOR REINSURANCE SECURED BY FUNDS WITHHELD

Code Section 922.5 permits a domestic insurer to claim credit on its financial statements for a cession to an unauthorized reinsurer if the reinsurer provides specified collateral to guarantee its obligations under the reinsurance agreement. This section interprets and implements Code Section 922.5(a)(1), which permits the collateral to be in the form of funds held by the ceding insurer pursuant to the reinsurance agreement. Although this section is generally based on the Model Regulation, it includes additional requirements that the Commissioner has determined are necessary to comply with California law and to protect the interests of the domestic ceding insurer, its policyholders and creditors.

§2303.9(a) This subdivision follows the Model Regulation and specifies requirements applicable to domestic insurers claiming credit on their financial statements for cessions secured by a funds held reinsurance agreement.

The subdivision expands upon the Model Regulation by providing that credit will not be permitted unless the cession meets the applicable requirements of Sections 2303.11 through 2303.13 of the regulations. This condition is necessary to comply with California law, as follows:

> Pursuant to Code Section 922.2, credit for reinsurance is not permitted unless the reinsurance agreement meets certain requirements. These requirements are clarified and interpreted in Section 2303.13.
>
> Pursuant to Code Section 922.3, credit for reinsurance is not permitted unless "the reinsurer undertakes to indemnify the ceding insurer, not only in form but in fact, against all or a part of the loss or liability arising out of the original insurance." This requirement is known as "risk transfer", and is clarified and interpreted in Sections 2303.11 and 2303.12.

> Pursuant to Code Section 923, licensees must comply with those provisions of the NAIC Accounting Guidance that do not conflict with the Code. Requirements from the NAIC Accounting Guidance relating to credit for reinsurance are specified, clarified and interpreted in Section 2303.13.

This subdivision is reasonably necessary to interpret and implement Code Section 922.5(a)(1), to specify the requirements applicable to funds held reinsurance agreements, and to promote uniformity of standards among the states to the extent possible under California law.

§2303.9(b) This subdivision defines the term "unencumbered funds withheld" used in the Model Regulation and in subdivision (a) of this section. The term is not defined in the Model Regulation. Code Section 922.5(a)(1) expressly requires that the funds held under a reinsurance agreement must be held under the exclusive control of the ceding insurer. The subdivision states that funds held in an escrow or trust account would not meet the Code requirement. In such arrangements, the funds would not be held under the *exclusive* control of the ceding insurer as required by the Code.

This definition is reasonably necessary to clarify and make specific Code Section 922.5(a)(1), to specify the proper manner in which funds must be held in order to claim statement credit for the reinsurance, and for the efficient and effective implementation of Code Section 922.5(a)(1).

§2303.9(c) The other subdivisions of this section are applicable only to *domestic* insurers. However, this subdivision specifies that credit on a financial statement of a *foreign* insurer shall be allowed for reinsurance ceded to an unauthorized reinsurer and secured by funds held under the agreement, to the extent that credit is allowed by the foreign insurer's state of domicile, unless the Commissioner has made a determination pursuant to Section 2303.10(d) of these regulations that the transaction does not meet, in substance, the requirements of this section.

This subdivision is reasonably necessary to clarify the relationship between this section and Section 2303.10, as well as the relationship between the Code sections upon which those sections are based: Code Sections 922.5(a)(1) and 922.6(b). This subdivision is reasonably necessary for the efficient and effective implementation of Code Section 922.6(b).

§2303.9(d) This subdivision is reasonably necessary for the efficient organization of the regulations in that it specifies that denial of statement credit under this section shall be made in the manner prescribed in Section 2303.19(c) of the regulations. This subdivision is reasonably necessary for the efficient and effective implementation of Code Section 922.5.

§2303.10 CREDIT FOR REINSURANCE OF FOREIGN INSURERS

This section concerns credit for reinsurance claimed on the financial statements of foreign insurers for cessions to reinsurers that are *unauthorized* in California. (Sections 2303.3, 2303.4 and 2303.5 of this article permit statement credit for a foreign insurer's cession to a

reinsurer *authorized* in California [licensed insurers, accredited reinsurers, and reinsurers which maintain approved U.S. trusts].)

Code Section 922.6(a) permits credit for reinsurance claimed by a foreign ceding insurer if credit is allowed by the foreign insurer's state of domicile, and either (1) the domiciliary state has been accredited by the NAIC, or (2) the credit would be permitted if the foreign insurer were domiciled in California. Virtually all states have been accredited by the NAIC, although the list of accredited states changes over time as states gain, lose and regain accreditation. Code Section 922.6(b) provides that, notwithstanding subdivision (a), statement credit may be denied if the Commissioner makes a finding that the condition of the reinsurer or the collateral provided does not meet the credit for reinsurance standards applicable to domestic insurers.

In most instances the Commissioner does not question statement credit permitted by a domiciliary state. However, where the credit is claimed for reinsurance with a reinsurer unauthorized in California, occasionally questions do arise. For example, if the reinsurance credit claimed is very significant to the ceding insurer (i.e., its loss could result in financial hazard or insolvency) and the reinsurer has been the subject of press or industry reports where its financial condition has been questioned, or the domiciliary state regulator has significantly less oversight resources than is available to California, the Commissioner may be uncertain that the condition of the reinsurer or the collateral provided would meet the standards applicable to domestic insurers. In such instances, the Commissioner may determine to apply the provisions of Code Section 922.6(b). This section clarifies and makes specific the requirements of Code Section 922.6(b).

Code Section 922.6(b) provides that:

> "*Notwithstanding subdivision (a),* credit for reinsurance … may be disallowed upon a finding by the commissioner that either the condition of the reinsurer, or the collateral or other security provided by the reinsurer, does not satisfy the credit for reinsurance requirements applicable to ceding insurers domiciled in this state." (Emphasis added.)

Code Section 922.6 (b) permits the denial of statement credit allowed by the home state, "*notwithstanding (a)"* -- which means notwithstanding *either* (a)(1) -- the insurer is domiciled in an accredited state *or* (a)(2) -- the insurer is not domiciled in an accredited state but the credit would be allowed if it were domiciled in California.

In the analysis of this statute it is critical to note that the requirements of subdivision 922.6(b) (reinsurer or collateral must satisfy credit for reinsurance standards applicable to domestics) have effect only when applied to insurers meeting the requirements of 922.6(a)(1) (from accredited states), in that insurers meeting the requirements of 922.6(a)(2) (credit permitted if the credit would be allowed if the insurer was a domestic) would not be subject to any different requirements under 922.6(b).

This section is reasonably necessary to interpret, clarify and implement Code Section 922.6(b).

§2303.10(a) This subdivision notifies foreign insurers that they must comply with all reinsurance accounting requirements for the preparation of financial statements for filing in California, except those requirements that are expressly made applicable only to domestic insurers. This subdivision is reasonably necessary to clarify application of the regulations.

§2303.10(b) This subdivision provides notice that credit may be denied for reinsurance ceded to an unauthorized reinsurer, if the Commissioner makes a finding that the condition of the reinsurer or the collateral provided does not meet the credit for reinsurance standards applicable to domestic insurers. This subdivision is reasonably necessary to clarify the standards applicable to a foreign insurer claiming statement credit for a cession to a reinsurer that is unauthorized in California.

§2303.10(c) This subdivision provides that where credit is claimed on the basis that the unauthorized reinsurer is either licensed or accredited in the foreign insurer's state of domicile, the reinsurer must, in substance, meet either the licensing or accreditation standards of California. The subdivision also provides that where credit is claimed on the basis of security in the form of a trust agreement, letter of credit, or funds held agreement, the security must, in substance, meet the standards for like security in California. This subdivision is reasonably necessary to clarify the requirements applicable to a foreign insurer claiming statement credit for a cession to a reinsurer that is unauthorized in California.

§2303.10(d) This subdivision requires a foreign insurer to provide all information and documentation as may be requested to enable the Commissioner to establish to his or her satisfaction that the credit for reinsurance standards applicable to domestic insurers have been met. The requirement to provide documents upon request for this purpose has been in effect since 1997 through Bulletin 97-5, and the Department has made few such requests in that period. The requirement is minimally burdensome upon foreign insurers, and is reasonably necessary to enable the Commissioner to assess whether the statement credit claimed meets the standards applicable to domestic insurers.

The subdivision provides that if the information and documentation submitted by the foreign insurer does not establish to the Commissioner's satisfaction that the requirements of subdivision (c) of this section have been met, credit for the reinsurance shall be denied in the manner prescribed in Section 2303.19(c) of this article.

This subdivision is reasonably necessary to specify the procedures applicable to a foreign insurer claiming statement credit for a cession to a reinsurer that is unauthorized in California for the effective and efficient enforcement of Code Section 922.6.

§2303.10(e) This subdivision provides that the foreign insurer shall pay the cost of examination of the documents and information submitted to the Department pursuant to the requirements of subdivision (d) of this section. Code Section 736 requires the Commissioner to collect all costs of examination from licensees, except that the

Commissioner may, in his discretion, waive reimbursement for "special" examinations. The Commissioner has determined that the examination provided for in this section is not a "special" examination, which is performed when an insurer may be financially impaired. However, if the examination provided for in this section would be termed a "special" examination, the Department is without the resources to absorb the costs of such examination and the Commissioner elects not to waive recovery of the examination costs. Therefore, this section is reasonably necessary to notify foreign insurers that they will be required to pay for the cost of examination of documents submitted pursuant to Section 2303.10(d).

§2303.11 TRANSFER OF RISK – LIFE & DISABILITY

Pursuant to Code Section 922.3, credit for reinsurance is not permitted unless "the reinsurer undertakes to indemnify the ceding insurer, not only in form but in fact, against all or a part of the loss or liability arising out of the original insurance." This requirement is known as "risk transfer" and this section applies only to risk transfer in life and disability reinsurance agreements. This section interprets and implements Code Section 922.3.

This section generally follows Appendix A-791 of the NAIC Accounting Guidance, which includes the model regulation for life and disability risk transfer. These requirements were included in Section 12 of Bulletin 97-5, which was issued by the Commissioner on December 3, 1997, as expressly permitted by Code Section 922.8, and have been included in this section. Except as noted below, the text of this section generally copies the language of Appendix A-791 verbatim, with only non-substantive changes in grammar, format and numbering.

Substantive changes from Appendix A-791 are necessary to conform to California law, to resolve ambiguities present in Appendix A-791, and to make explicit the requirement of Code Section 922.3 that, in order for the ceding insurer to reduce its liability or establish assets in its financial statement, the risks of the underlying policies being reinsured must be transferred to the reinsurer or the assuming insurer. This section is reasonably necessary to promote uniformity among the states that have adopted the model regulation in Appendix A-791, to the extent such uniformity is permitted by California law.

Following are the substantive changes that are not included in Appendix A-791:

§2303.11(b) The following sentence has been added to this section:

> "Except as provided in the Statutory Account Principles ("SSAP") 61 of the NAIC Accounting Guidance, it shall also not apply to yearly renewable term reinsurance ("YRT"), as described in SSAP 61, that provides reserve credit not greater than up to one year's valuation mortality rate."

This language clarifies which YRT reinsurance agreements are exempt from the risk transfer requirements of this section, based on the amount of reserve credit being taken by the ceding company. On the average, the YRT reserve credit will be one-half of one year's valuation mortality rate but can be as large as a full year's rate if all policies were issued near the end

of the calendar year. This language also provides clarification that not all YRT reinsurance agreements are exempt from the risk transfer requirements of this Section. It is necessary to include this language in this subdivision to ensure that the reserve credit taken by the ceding insurer in its financial statement properly reflects the risks being transferred to or assumed by the reinsurer. This subdivision is reasonably necessary to clarify and interpret Code Section 922.3.

§2303.11(c)(2) This paragraph is intended to prohibit the ceding insurer from suffering depletion in assets or surplus at the reinsurer's option, **at a specified time scheduled in the reinsurance agreement,** or automatically upon the occurrence of some event, such as the insolvency of the ceding insurer. The language, **"at a specified time scheduled in the reinsurance agreement"**, has been added to this subsection to include contract provisions which could cause a depletion in the ceding insurer's surplus at a specified time scheduled in the reinsurance agreement. The element of uncertainty is one of the risks of reinsurance. It could be financially detrimental to the ceding insurer and its policyholders if the ceding insurer were to suffer depletion in surplus at a critical time because the contract provided for such to occur. This paragraph is reasonably necessary to interpret and implement Code Section 922.3

§2303.11(c)(4) This paragraph provides that a contract for which statement credit is claimed may not allow the reinsurer to unilaterally terminate the agreement or require the ceding insurer to automatically recapture all or part of the reinsurance ceded.

It is necessary to include this paragraph to clarify that a reinsurer may not unilaterally terminate the agreement, except upon the nonperformance of the ceding insurer as provided in paragraph (c)(2) of this section. Reinsurance of in-force business must continue based on the life of the policies being reinsured unless the ceding insurer agrees to an earlier termination date. A provision that would allow the reinsurer to unilaterally terminate an agreement covering in-force business, or require the ceding insurer to recapture the business, violates the risk transfer requirements of Code Section 922.3, in that the requirement to indemnify the ceding insurer would be in form but not in fact. This paragraph is reasonably necessary to clarify and interpret Code Section 922.3.

§2303.11(c)(8) This paragraph provides that a contract for which statement credit is claimed must require payment in cash by the reinsurer of amounts "receivable" within *thirty* days of the settlement date. Appendix A-791 and Bulletin 97-5 used language that requires payment of amounts "due" within *ninety* days of the settlement date. (The settlement date must be not less frequently than quarterly.)

Although "due" and "receivable" appear to have the same meaning, dictionary definitions of "due" give the meaning as "expected or scheduled to arrive" while "receivable" is given the meaning of "requiring payment". Therefore, "receivable" is a more appropriate term in the context of this paragraph, requiring actual payment to be made within a specific period of time.

The language regarding payment within ninety days of settlement date included in both Appendix A-791 and Bulletin 97-5 has been changed to require payment within thirty days. Settlement reports must be submitted at least quarterly. Payment within ninety days of the settlement date would permit indemnification for a loss that had been paid by the ceding insurer on the first day of a calendar quarter to be considered timely paid if payment was received ninety days after the settlement report submitted at the end of the quarter – an indemnity delay of almost six months. Such a length of time violates a fundamental principle of risk transfer that payment must be made without delay. The Commissioner has determined that payment within thirty days of the date of settlement is a reasonable period to require payment, and consistent with the requirements of risk transfer. This paragraph is reasonably necessary to interpret and implement Code Section 922.3

§2303.11(d) This subdivision provides that the Commissioner may allow statement credit for the agreement, notwithstanding that the agreement does not meet the requirements of subdivision (c) of this section, as the Commissioner considers appropriate. This language is included in both Appendix A-791 and Bulletin 97-5. However, the subdivision adds a caveat from Bulletin 97-5 that is not included in Appendix A-791, that any such allowance by the Commissioner shall not be deemed approval of the reinsurance treaty nor shall it be considered an indication that reinsurance credit may be allowed for other similar treaties. Approval of an agreement and the allowance of statement credit are made on a case-by-case basis, wherein various aspects of the transaction are considered, including, e.g., the contract terms, the purpose of the arrangement, and the financial strength of the reinsurer.

The requirement is necessary to clarify that permitting an exception to the requirements of subdivision (c) in one instance as may be appropriate under the circumstances, is not a "blanket approval" of the exception for other agreements. This subdivision is reasonably necessary to interpret and implement Code Section 922.3.

§2303.11(e) The filing requirement of this subdivision is not in Appendix A-791 but is present in Bulletin 97-5. This subdivision requires insurers to file copies of agreements and financial impact information concerning reinsurance of business issued prior to the effective year of the agreement and specifies requirements for financial reporting. This subdivision is reasonably necessary to interpret and implement Code Section 922.3

§2303.11(g) This subdivision was included in Bulletin 97-5 and clarifies that the appointed actuary should consider the insurance company's reinsurance agreements in his/her actuarial opinion of the company's reserve liability, as reported in the financial statement. This is also a form of notification, pursuant to the examination authority of the department, that actuarial information regarding the reinsurance agreement may be required in conjunction with department's review of the reinsurance agreement. The actuary shall therefore maintain adequate documentation to support the reserve credit taken in the ceding company's financial statements, based upon the extent of risks of the reinsured business that are being transferred to the reinsurer, and be prepared to furnish this information upon request. This subdivision is reasonably necessary to interpret and implement Code Section 922.3

§2303.11 (i) This subdivision provides that all contracts between the ceding insurer, the reinsurer, and their affiliates, may, in the Commissioner's discretion, be reviewed in the determination of risk transfer. This requirement is not in Appendix A-791 or Bulletin 97-5. The purpose of this subdivision is to allow the Department access to any other contracts between the reinsured parties and their affiliates, the effects of which may be to diminish the transfer of risks to the reinsurer or to delay the timely reimbursement of claims by the reinsurer, while the ceding company takes credit for reinsurance. This is the "whole picture" approach. The insurance industry has, in recent years, been scandalized by intentional "window-dressing" of insurer financial statements through separate agreements between companies and their affiliates. Such agreements were hidden from regulators, and had the effect of transforming a reinsurance agreement to a financing scheme. This subdivision is intended to prevent the use of side agreements to avoid risk transfer, and is reasonably necessary to clarify and make specific the requirements of Code Section 922.3.

2303.11(j) This subdivision provides that denials of credit for reinsurance under this section shall be made in the manner specified in Section 2303.19, which sets procedures for such denials. This subdivision is reasonably necessary for consistent and efficient organization of the requirements of this article.

§2303.12 TRANSFER OF RISK – PROPERTY & CASUALTY

Pursuant to Code Section 922.3, credit for reinsurance is not permitted unless "the reinsurer undertakes to indemnify the ceding insurer, not only in form but in fact, against all or a part of the loss or liability arising out of the original insurance." This requirement is known as "risk transfer" and this section applies only to risk transfer in property and casualty reinsurance agreements. This section interprets and implements Code Section 922.3.

Section 2303.12(a) This subdivision provides that transfer of risk shall be determined by application of the NAIC Accounting Guidance, in a manner consistent with the following principles:

1. A reinsurance agreement must transfer an insurance risk for which there is a reasonable possibility of a significant loss to the reinsurer.

2. Recoveries due to the ceding insurer under a reinsurance agreement must be available without delay, in a manner consistent with the orderly payment of incurred policy or contract obligations by the ceding insurer.

The NAIC Accounting Guidance is made applicable to licensed insurers through the provisions of Code Section 923. The NAIC Accounting Guidance regarding risk transfer for property and casualty insurance includes explanations, exposition, caveats, examples, conditions and mandates (*see* SSAP 62:9-16), developed in response to the myriad of arrangements requiring risk transfer analysis to determine whether the arrangement is, in fact, reinsurance and not a financing arrangement. The NAIC is revising its instructions regarding risk transfer analysis in response to the discovery in 2004 by the New York Attorney General of the use of financing schemes masquerading as reinsurance by several major insurers.

Although the risk transfer section in the NAIC Accounting Guidance is broad in scope, it does not define or quantify key words and phrases such as "significant insurance risk," "significant loss" and "remote" to aid in determining whether a particular reinsurance agreement meets the requirements.

The Commissioner has determined that the NAIC Accounting Guidance risk transfer requirements must be applied in a manner consistent with the fundamental *principles* of risk transfer. This subdivision is reasonably necessary to promote consistency in the application of the risk transfer requirements of the NAIC Accounting Guidance and to interpret and implement Code Section 922.3 and 923.

§2303.12(b) This subdivision provides that in the review of a reinsurance agreement to evaluate transfer of risk, all contracts between the ceding insurer, the reinsurer, and their respective affiliates, may, in the Commissioner's discretion, be reviewed to determine whether any provision may (1) limit the amount of insurance risk to which the reinsurer is subject under the agreement, or (2) delay the timely reimbursement of claims by the reinsurer.

This requirement is based on the review instructions in the risk transfer analysis section of the NAIC Accounting Guidance (*see* SSAP 62:11). This subdivision is reasonably necessary to inform licensees of the scope of the information that may be required in the Department's analysis of a reinsurance transaction.

§2303.12(c) This subdivision informs affected persons that denial of statement credit under this section shall be made in the manner prescribed in Section 2303.19(c) of the regulations. This subdivision is reasonably necessary for the efficient and effective enforcement of Code Section 922.3.

§2303.13 CONTRACT REQUIREMENTS FOR STATEMENT CREDIT

This section prescribes the contract provisions that must be included within specified reinsurance agreements in order to claim statement credit for the cessions.

§2303.13 (a) This subdivision specifies the provisions that must be included within the material reinsurance agreements of domestic insurers and volume insurers. The limitation of application is intended to reduce the compliance burden on licensees and the oversight burden on the Department. The provisions are based on requirements in the NAIC Accounting Guidance, which is made applicable to all licensees pursuant to Code Section 923. Certain of the NAIC requirements have been modified in a manner the Commissioner has determined necessary in order to elicit from licensees a true exhibit of their condition, as is permitted by Code Section 923.

This subdivision is necessary to provide a comprehensive checklist of required provisions to be included in the material reinsurance agreements of domestic insurers and volume insurers. This subdivision is reasonably necessary to clarify and make specific the requirements of Code Section 923.

§2303.13(a)(1) This paragraph requires that a reinsurance agreement must expressly disclose, within the agreement or in an exhibit incorporated by reference, every separate contract which would under any circumstances reduce, limit, mitigate or otherwise affect any actual or potential loss to the parties under the agreement.

The Commissioner has determined that this disclosure requirement is necessary after the discovery in 2004 of the use of "side agreements" by insurers to reduce or avoid the transfer of insurance risk to reinsurers. The use of "side agreements" was discovered in the investigation of the insurance industry conducted by New York Attorney General Elliot Spitzer. By use of side agreements hidden from the Commissioner and other regulators, some reinsurance agreements were effectively financing arrangements.

The NAIC moved quickly to address the issue by requiring each insurer to file with its annual statement an attestation by its chief officers made under penalty of perjury that discloses all separate agreements that may reduce or limit loss in the reinsurance agreements reported in the insurer's annual statement. The NAIC disclosure requirement applies to annual statements filed for 2005 and thereafter.

The Commissioner believes a disclosure requirement is more effective if it is included within the reinsurance agreement itself. An undisclosed side agreement could materially change the terms of the reinsurance agreement. A regulator could consent to a transaction only to learn at the next annual statement filing of the existence of a side agreement, which if known at the time a transaction was reviewed may have precluded consent or required a revision in the terms of the agreement. Requiring disclosure of separate agreements within the reinsurance agreement itself ensures a full and complete disclosure because the parties will be bound by it, and will permit review of those separate agreements by regulators at the time of review of the reinsurance transaction.

The language used in the regulation to specify the separate contracts that are required to be disclosed (" those which would under any circumstances reduce, limit, mitigate or otherwise affect any actual or potential loss to the parties under the agreement") is verbatim language from the NAIC disclosure requirement for filing with the 2005 annual statements. Use of the verbatim language means that any separate contract an insurer is required to disclose in the NAIC attestation will be required to be disclosed within the reinsurance agreement. Use of the verbatim language will permit any clarifications issued by the NAIC to be used to interpret the regulation.

This paragraph also provides that by notice sent to licensees with the Annual Statement Instructions and published on the Department's website, the Commissioner may limit the disclosure requirement of this paragraph to those separate contracts required to be disclosed in the then current NAIC Reinsurance Attestation Supplement to be filed with a licensed insurer's annual statement. The separate agreement and disclosure requirement is an evolving issue at the NAIC. In the event the NAIC revises the language used to describe which separate contracts must be disclosed in the 2006 annual statement or thereafter, this provision would permit the Commissioner to adopt that disclosure language through notice in

the Annual Statement Instructions. Without this provision, the timing of the NAIC change could result in a lack of uniformity if a change in the California disclosure requirement had to be delayed until such time that the regulation is formally amended.

This paragraph is reasonably necessary to ensure that all separate agreements that may affect risk transfer are disclosed at the time the transaction is reviewed by the Department. This paragraph is reasonably necessary to clarify and implement the risk transfer requirement of Code Section 922.3, and the financial reporting requirements of Code Section 923.

§2303.13(a)(2) This paragraph provides that the reinsurance agreement shall state that it constitutes the entire agreement between the parties with respect to the business covered by the agreement and that there are no understandings between the parties other than as expressed in the agreement, except for the separate contracts expressly disclosed. This provision is based upon a requirement in the NAIC Accounting Guidance that states the agreement "shall constitute the entire contract between the parties…" (S*ee* SSAP 62:8(c).)

The NAIC provision is not required to be included within the agreement itself. Whether a reinsurance agreement in fact constitutes the "entire contract between the parties" is a matter of legal opinion if the limitation language is not included within the reinsurance agreement. The NAIC rule is followed and enforced primarily by non-attorney personnel employed by insurers and regulators. Including the requirement as an affirmative statement within the reinsurance agreement will more effectively and efficiently ensure compliance with the requirement. Moreover, including the requirement within the reinsurance agreement will ensure full disclosure of separate contracts under paragraph (a)(1) of this section.

This paragraph is reasonably necessary to ensure that all separate agreements that may affect risk transfer are disclosed at the time the transaction is reviewed by the Department. This paragraph is reasonably necessary to clarify and implement the financial reporting requirements of Code Section 923, and to implement Code Section 922.3.

§2303.13(a)(3) This paragraph specifies times for the ceding insurer's preparation of settlement reports and payment by the reinsurer. The regulation clarifies an ambiguity in a corresponding requirement of the NAIC Accounting Guidance, which did not specify the time payment was due from the reinsurer (*see* SSAP 62:8(d)). This paragraph is reasonably necessary to clarify and make specific the financial reporting requirements of Code Section 923.

§2303.13(a)(4) This paragraph is based on requirements in the NAIC Accounting Guidance. (S*ee* SSAP62:8.) Only non-substantive changes have been made for clarity, formatting and style. The requirements are limited in application to property and casualty risks, in recognition of the difference in reporting requirements applicable to life and disability insurers. Although this paragraph duplicates requirements in the NAIC Accounting Guidance, it is reasonably necessary in order to provide one comprehensive checklist of required provisions to be included in the material reinsurance agreements of domestic insurers and volume insurers. This paragraph is reasonably necessary to clarify and implement the financial reporting requirements of Code Section 923.

§2303.13 (b) This subdivision specifies the additional requirements applicable to all the reinsurance agreements of domestic insurers. This subdivision clarifies and interprets the requirements of Code Section 922.2(a)(2).

§2303.13(b)(1) This paragraph specifies the requirements for the insolvency clause prescribed by California Insurance Code ("Code") Section 922.2(a)(2). An acceptable insolvency clause must provide in substance that in the event of the insolvency of the ceding insurer, the reinsurer must pay to the liquidator the portion of the risk assumed, on the basis of claims allowed by the liquidator, without diminution because of the insolvency.

All states require the inclusion of an insolvency clause within a reinsurance contract if the ceding insurer claims statement credit for the cession. Although reinsurance is a contract of indemnity, when an insolvency clause is triggered the contract becomes one of liability wherein the reinsurer is obligated to pay the liquidator its allocated share of any losses due under the reinsurance contract even though the insolvent ceding company has not first made payment to the insureds on the underlying policies. The insolvency clause has its origin as a response by the states to the Supreme Court's decision in *Fidelity & Deposit Co v Pink* 302 US 224 (1937) (hereafter, *Pink*) that a reinsurer was liable to an insolvent insurer only for the amount the liquidator paid on a claim.

The insolvency clause statutes of virtually all states require a reinsurance agreement to provide that in the event of the insolvency of the ceding insurer the reinsurer shall pay the liquidator "the reinsurance" on the basis of the liability of the ceding insurer on the contracts reinsured, without diminution because of the insolvency of the ceding insurer.

However, the California insolvency clause statute is unique in the nation. It requires the contract to state that in the event of insolvency of the ceding insurer, the reinsurer shall pay the liquidator "the portion of any risk or obligation assumed" on the basis of claims allowed by the liquidator, without diminution because of the insolvency.

There would generally be a significant difference between the amount calculated as due from the reinsurer under an insolvency clause using "the reinsurance" language, and the amount calculated as due using "the portion of any risk or obligation assumed" language. To determine the amount the reinsurer owes under the California insolvency clause language, the only relevant text in the reinsurance agreement is that which describes the "portion of any risk or obligation risk assumed" by the reinsurer. However, to determine the amount the reinsurer owes under the insolvency clauses required by the other states wherein the reinsurer must pay "the reinsurance," the reinsurance contract must be read and applied in its entirety, with all its terms and conditions including, e.g., an obligation to pay only the net amount due.

The literal application of the California insolvency clause language would require the reinsurer to pay the liquidator its gross liabilities under the contract ("the portion of any risk or obligation assumed"), whereas, under a clause requiring it to pay "the reinsurance," the reinsurer would pay only its net liabilities. In a typical 50% quota share agreement, where the reinsurer assumed 50% of the losses, under the California insolvency clause language the

reinsurer would be required to pay the liquidator the portion of the risk it had assumed on the basis of claims allowed, or 50% of a claim allowed in the liquidation proceeding, without a reduction for netting or set-off (e.g., for unpaid premium) that might be available to the reinsurer under the insolvency clause language used by other states.

Because the provisions of Code Section 922.2(a)(2) are required to be included only "in substance", domestic insurers have routinely used insolvency clauses with "the reinsurance" language required by other states instead of "the portion of any risk or obligation assumed" language used in the California statute. The domestic insurers claimed that the "in substance" requirement was met with the inclusion of the "without diminution" language. As a result, only a very few of the thousands of reinsurance agreements of companies liquidated in California have contained insolvency clauses with the "portion of any risk or obligation assumed" language that is required by by the statute. In order for language to meet the "in substance" requirement of Code Section 922.2, it must provide the same result , which is not the case when "the reinsurance" is used instead of "the portion of any risk or obligation assumed" to define a reinsurer's payment obligation in liquidation.

This paragraph is reasonably necessary to clarify and make specific the requirements of Code Section 922.2(a)(2) by notifying domestic insurers that reinsurance agreements for which they claim statement credit must specifically include the essential provisions of the California insolvency clause and not just the generic recitations permitted by other states.

§2303.13(b)(2) This paragraph requires the insolvency clause to also include the following language:

> "Notwithstanding any other provision of this agreement, in the event of the insolvency of the ceding insurer, no provision may reduce the payment to the conservator, liquidator or statutory successor required of the reinsurer by the insolvency clause."

Reinsurance contracts are often complex documents of many pages. A regulator may not understand that a reference to "insolvency" on, e.g., page 17 may have the effect of limiting the payment that would otherwise be required by an insolvency clause contained on, e.g., page 32. This requirement is reasonably necessary to ensure that the insolvency clause requirements of Code Section 922.2(a)(2) are fully implemented.

§2303.13(b)(3) This paragraph states that an insolvency clause may also contain any or all the remaining provisions of Code Section 922.2(a)(2). This paragraph is reasonably necessary to make clear that an acceptable insolvency clause is not limited to the provisions required in paragraphs (b)(1) and (b)(2) of this section.

§2303.13(b)(4) This paragraph provides a definition for the term "statutory insolvency clause" as including the first sentence of Code Section 922.2(a)(2) verbatim, except that company names, as defined in the agreement, may be substituted for "the ceding company" and "the reinsurer". This definition is reasonably necessary to provide a

convenient reference in communications concerning the requirements of Code Section 922.2(a)(2).

§2303.13(b)(5) This paragraph provides that if the agreement contains a set-off (or "offset") clause, it shall not expressly permit its application in conservation, liquidation or receivership proceedings.

The California insolvency clause requires the reinsurer "to pay the portion of any risk or obligation assumed". The literal application of that language would not permit a set-off, because a set-off would permit the reinsurer to pay *less* than the portion of the risk assumed. Therefore, a set-off clause that expressly permits its application in insolvency proceedings is directly contrary to Code requirements. Since setoff clauses often include language expressly permitting their application in insolvency proceedings, this requirement is necessary for effective implementation of Code Section 922.2(a)(2).

The paragraph also states that a set-off clause may provide that in the event of the insolvency of a party to the agreement, set-off may be allowed to the extent permitted by law. The meaning of the phrase "the portion of any risk or obligation assumed" to be included in a California insolvency clause has not been judicially interpreted. This paragraph permitting the inclusion of a set-off clause subject to applicable law is reasonably necessary in that it will permit a reinsurer to preserve a right of set-off in the event a court determines that the "portion of any risk or obligation assumed" language in the California insolvency clause does not preclude the application of a set-off to reduce a reinsurer's payment to the liquidator.

§2303.13(b)(6) This paragraph states that if the agreement includes an arbitration provision that excuses the arbitrators from strictly following the terms of the agreement or the rules of law, the provision shall expressly exclude its application to the insolvency clause.

Arbitration clauses often contain provisions that permit the arbitrators to disregard the specific provisions of the contract as well as the rules of law. By such provisions, arbitrators are permitted to give effect to the "intent" of the parties to the reinsurance agreement. Unless the insolvency clause is excluded from such a disregard provision, the arbitrators could disregard the express language of the insolvency clause within a contract containing "the portion of any risk or obligation assumed" language, and permit a set-off to reduce the reinsurer's payment to a liquidator. The arbitrators could determine that it was the "intent" of the parties to permit a set-off, and that the insolvency clause was given effect through requiring payment from the reinsurer on the basis of liability and not indemnity.

An arbitrator's interpretation of the California insolvency clause and the "intent" of the parties cannot be permitted to avoid the specific requirements of the Code. This paragraph is reasonably necessary for effective implementation of Code Section 922.2(a)(2).

§2303.13(c) This subdivision clarifies and interprets Code Section 922.2(a)(2) by defining the term "the portion of any risk or obligation assumed by the reinsurer" as meaning "all the risk assumed by the reinsurer under the reinsurance agreement, without application of a set-

off." This subdivision also defines "set-off" to include recoupment, netting, offset, or any term or procedure that would have the effect of reducing an amount otherwise owed.

At first blush this definition may seem unnecessary, in that it states the literal meaning of the term defined. If a reinsurer is required to pay the liquidator "the portion of any risk or obligation assumed", then by definition, the reinsurer could not apply a set-off and pay *less* than the portion of the risk assumed.

Reinsurers dispute that the California insolvency clause is to be read literally, insisting that the only purpose of an insolvency clause is to change the contract from one of indemnity to one of liability, requiring payment to the liquidator, whether or not the liquidator had paid a claim. Courts that have considered the application of an insolvency clause in liquidation proceedings have emphasized that the purpose of an insolvency clause is to overcome the holding of *Pink*. (See, e.g., *Prudential Reinsurance Company v. Superior Court of Los Angeles*, 2 Cal. 4th (1992) 1118, 1133-11344, (hereafter, *Prudential*) citing *Matter of Midland Ins. Co*. (N.Y. 1992) 79 N.Y.2d 253, 582 N.Y.S.2d,58, 590 N.E. 2d,1186, 1192 (hereafter *Midland*).] But no court has specifically analyzed "the portion of any risk or obligation assumed" language required by Code Section 922.2(a)(2) to determine whether a broader purpose was intended than merely to overcome *Pink.*

The claim is made that the availability of reinsurance set-offs in liquidation in California was settled in *Prudential*, which involved the liquidation of Mission Insurance Company wherein the Commissioner demanded payment without set-off from Mission's 144 reinsurers. The Commissioner argued, *inter alia*, that the set-offs were effectively precluded by the priority statute (Code Section 1033), that they did not meet the "mutuality" requirements of Code Section 1031 to permit set-off, and that set-off would violate the "without diminution" language of the insolvency clauses within the contracts. The Court disagreed.

However, none of the reinsurance contracts at issue in *Prudential* contained the insolvency clause language required by the Code; the insolvency clauses in the contracts before the Court required only that "the reinsurance" be paid. (*Prudential*, *supra*, at 1127.) Therefore, there was no need to analyze Code Section 922.2 or the phrase, "the portion of any risk or obligation assumed"; the language was not relevant to the issues before the Court. In fact, the Court mentioned the insolvency clause statute only briefly and in dicta, stating:

> Section 922.2 requires all reinsurance contracts to contain an "insolvency clause" allowing the liquidator to collect from the reinsurer the amount that would have been due if the ceding company had not become insolvent.
> …
> …(T)he purpose of section 922.2 and the insolvency clause is to provide the liquidator with the same rights and obligations of the insolvent insurer pursuant to the terms of the reinsurance contract.

(*Prudential*, *supra*, at 1133-1135)

The lack of necessity to analyze Code Section 922.2 explains the Court's failure to note the different language used in the California insolvency clause statute and the insolvency clause statutes in *Midland* and other cases it cited**.** Without a reason to analyze Code Section 922.2, the *Prudential* court had no reason to consider whether the unique language used had a purpose beyond Pink.

When the California insolvency clause was first adopted in 1949**,** early drafts of the legislation contained the insolvency clause language used by other states and required the reinsurer to pay "the reinsurance" to the liquidator. That language was changed to "the portion of any risk or obligation assumed" in the final legislation. The "portion of any risk or obligation assumed" requirement was codified in Code Section 922.2, in the second sentence of the second paragraph of that section.

After the 1992 *Prudential* decision where none of the insolvency clauses at issue contained the "portion of any risk or obligation assumed" language used in the California statute, the Commissioner began requiring that language to be included in the insolvency clauses of the reinsurance agreements of domestic ceding insurers. Had the *Prudential* agreements contained that language, the requirement for the reinsurers to pay "the portion of any risk or obligation assumed" could have preserved more than $300 million dollars for California policyholders that were lost to reinsurer set-offs in the Mission liquidation.

In 1995, in litigation with reinsurers concerning set-off, the Commissioner construed the phrase, "the portion of any risk or obligation assumed," as precluding set-off in liquidation to reduce payments due from reinsurers. The litigation was settled without resolving the meaning of the California insolvency clause language.

In 1996 the California credit for reinsurance statutes in Code Section 922.1 *et seq*. were revised in cooperation with the industry to achieve greater uniformity with the NAIC Model Law on Credit for Reinsurance ("Model Law"). The insolvency clause language of the Model Law required the reinsurer to pay "the reinsurance." The Model Law insolvency clause language used by the other states was not followed; instead, "the portion of any risk or obligation assumed" language from the existing statute was retained in Code Section 922.2(a)(2).

Following are the sections of the Code relevant to this analysis:

> 922.2. (a) Credit for reinsurance shall be allowed a domestic ceding insurer as either an asset or a deduction from liability in accordance with Sections 922.4 and 922.5 only if the reinsurance contract contains provisions that provide, in substance, as follows:
>
> (1) The reinsurer shall indemnify the ceding insurer for any portion of the risk it has assumed *according to the terms and conditions contained in the reinsurance contract.*
>
> (2) *In the event of insolvency* and the appointment of a

> conservator, liquidator, or statutory successor of the ceding company, *the portion of any risk or obligation assumed by the reinsurer shall be payable* to the conservator, liquidator, or statutory successor on the basis of claims allowed against the insolvent company by any court of competent jurisdiction or by any conservator, liquidator, or statutory successor of the company having authority to allow such claims, without diminution because of that insolvency, or because the conservator, liquidator, or statutory successor has failed to pay all or a portion of any claims.

(Emphasis added.)

The terms used in 922.2(a)(1) and 922.2(a)(2) are explicitly different. Paragraph (a)(1) applies *prior* to insolvency and requires the reinsurer to indemnify the ceding company for the portion of the risk it assumed "according to the terms and conditions contained in the reinsurance contract." In contrast, paragraph (a)(2) specifies the reinsurer's obligations *after* insolvency, and requires that, after the appointment of a receiver, the reinsurer shall pay the receiver "the portion of any risk or obligation assumed" on the basis of claims allowed by a court or the receiver. The insolvency clause requirement contains no mention of payment according to the "terms and conditions" of the reinsurance contract.

In analyzing the meaning of "the portion of any risk or obligation assumed" language used in Code Section 922.2(a)(2), it is helpful to understand the statutory framework in which it is found. The insolvency clause requirement is included in the Code sections relating to the requirements for the officially filed statutory financial statements of licensed insurers. (See Code Section 900, *et. seq*.) Under nationally applied accounting standards reflected in the statutes, statutory accounting procedures for insurers are more conservative than the generally accepted accounting principles followed by non-insurers. A statutory financial statement is prepared on a basis consistent with the concepts of conservatism, consistency and recognition. If a reporting insurer is liquidated, its financial statement as of the date of liquidation should accurately reflect its assets and liabilities as of that date in accordance with those concepts, particularly conservatism and recognition (see, for example, paragraph 33 of the NAIC Accounting Practices and Procedures Manual Preamble[1]). The concepts underlying statutory accounting are designed to minimize the risk to an insurer's policyholders and creditors. (See NAIC Accounting Practices and Procedures Manual Preamble, paragraphs 21-36.)

A set-off applied in liquidation permits a reinsurer to reduce its payment obligations for liabilities it had assumed under a reinsurance agreement. If a liquidated insurer had reduced the policy liabilities reported on its financial statements by taking credit for liabilities

[1] 33. The ability to meet policyholder obligations is predicated on the existence of readily marketable assets available when both current and future obligations are due. Assets having economic value other than those which can be used to fulfill policyholder obligations, or those assets which are unavailable due to encumbrances or other third party interests should not be recognized on the balance sheet but rather should be charged against surplus when acquired or when availability otherwise becomes questionable.

transferred to a reinsurer, the policy liabilities would be understated by any amount not paid by the reinsurer. The credit for the reinsurance would have been overstated, to the degree it was not fully realized in payments from the reinsurer.

Insurers will argue that they do report all relevant amounts recoverable and payable under ceded reinsurance contracts on their financial statements and their resultant reported surplus amounts reflect their financial position inclusive of any offsets. To a certain extent that is correct. Reinsurance recoverables on unpaid losses that may be offset by ceded premiums are not netted against ceded reinsurance premiums payable. Instead, reinsurance recoverables on unpaid losses are subtracted from gross losses (reducing the liability for losses) and ceded reinsurance premiums payable are reported as a separate liability. Therefore, when offset is allowed, considerable analysis beyond a quick reading and review of an insurer's financial statement balance sheet is required in order to determine the true amount of reinsurance recoverables available and, consequently the true liability for losses reported.

In addition, other amounts besides premiums owed to reinsurers and presumably available to offset reinsurance recoverables may not be reported or even be reportable under statutory accounting. For example, statutory accounting does not require a liability accrual for contracted payments under service agreements or long-term lease agreements.

To ensure accuracy in financial statements that are required to be prepared in accordance with conservative statutory accounting principles and concepts, it is reasonable to limit statement credit for reinsurance to those sums that will actually be paid by a reinsurer in a liquidation proceeding. "The portion of any risk or obligation assumed" language, literally applied, does just that: in the event of liquidation, the reinsurer must pay the portion of the risk it had assumed without reduction for netting or set-off. A reduction for set-off or netting could not be permitted, in that the payment would be *less* than the portion of the risk assumed.

Reinsurers argue that Code Section 1031, which *Prudential* held permits reinsurers to set off certain reinsurance obligations in liquidation proceedings, precludes an interpretation of Code Section 922.2(a)(2) in a manner that would not permit them. But the two statutes have entirely different purposes. Code Section 1031 states the requirements applicable to insurers and reinsurers to obtain set-offs in liquidation proceedings. Code Section 922.2(a)(2) states the requirements for *ceding insurers* to claim credit for reinsurance in their statutory financial statements.

Construing Code Section 922.2(a)(2) as precluding set-offs where statement credit is claimed would not render Code Section 1031 meaningless. Set-offs in liquidation would be permitted under Code Section 1031 for all amounts due under all agreements except those reinsurance agreements for which statement credit was claimed and which contain the "portion of any risk or obligation assumed" language. Set-offs in liquidation would be permitted for service agreements, rental agreements, lease agreements, investment agreements, consulting agreements, and any other transactions between the insurer and reinsurer. Set-offs in liquidation would be permitted under Code Section 1031 for the thousands of reinsurance

agreements of domestic ceding insurers already in effect that do not contain "the portion of any risk or obligation assumed" language. Set-offs in liquidation would be permitted under Code Section 1031 for all future reinsurance agreements where statement credit is not claimed and the "portion of the risk" language is omitted.

Reinsurers argue that permitting set-off of reinsurance liabilities in liquidation reduces the cost of reinsurance. In interpreting Code Section 1031, this policy argument was adopted by the *Prudential* court where it stated:

> To disallow setoff in this case would … lead to an increased cost of insurance for the consumer, because offsetting an insurer's debts spreads the risk incurred by the insurer and often allows smaller insurers to remain in business.

(*Prudential*, supra, at 1125.)

However, since statement credit for reinsurance was not relevant to the issues in *Prudential*, the court did not consider the policy and regulatory reasons that exist to preclude set-off in agreements where statement credit is claimed. The court did not consider, for example, that where statement credit is claimed, set-offs impair the ability of regulators to assess the true financial strength of insurers, permit inaccuracies in statutory financial statements, permit financially stressed insurers to operate on a "float" of unpaid premium, and permit under priced reinsurance subsidized by unsuspecting policyholders.

It is sometimes difficult for regulators to assess the true financial strength of a company when the reported liabilities are subject to reduction by set-off. Financial analysis is always difficult for regulators where set-offs may arise from multiple reinsurance contracts; the difficulty is compounded when setoffs arise from liabilities not reported on statutory financial statements, such as for contracted payments under service agreements or long-term lease agreements. Credit for reinsurance is overstated to the degree it is not fully realized in payments from the reinsurer. Financial statements filed by an insurer prior to liquidation grossly understate policy liabilities if potential set-offs are significant. Accuracy in financial statements is necessary for the efficient and effective regulation of insurers for the protection of policyholders and creditors. Accuracy in financial statement is also necessary for integrity in the financial strength ratings made by agencies such as A.M. Best, and to enable policyholders, agents, creditors and reinsurers to make informed decisions about whether to do business with a company.

The availability of set-offs to reduce a reinsurer's payment to a liquidator eliminates the reinsurer's incentive to closely monitor a ceding insurer's financial condition. A set-off allows lax enforcement of contract provisions by a reinsurer, which may permit a financially stressed ceding insurer to operate for an extended period on a "float" of unpaid premium, all the while issuing policies to unwary consumers. The reinsurer need take no action to force payment, secure in the knowledge it will recoup the premium through set-off if the company fails. A set-off increases the burden on the California Insurance Guarantee Association ("CIGA") by transferring to it liabilities avoided by set-off. Since CIGA is funded entirely

by policy surcharges on policyholders, consumers bear the ultimate cost of reinsurer liquidation set-offs. (*See* Code Sections 1063.14 and 1063.145, 1063.70.)

The claim that the preclusion of reinsurance set-offs in liquidation will have a significant adverse impact upon the cost and availability of reinsurance for domestic insurers is speculation. Initially, it is important to recognize that a reduced cost for reinsurance based on the availability of set-off is effectively under priced reinsurance, subsidized by the ceding insurer's unsuspecting policyholders and CIGA assessments on consumers. A set-off is a form of security. If insolvency set-offs are precluded in reinsurance agreements with domestic insurers where credit is claimed, a reinsurer has options to reduce the risk of non-payment of premium.

Prior to entering a reinsurance contract, a reinsurer could more closely scrutinize the financial strength of a potential ceding insurer; while this might reduce the availability of reinsurance for marginal insurers, there is little public benefit in propping up a weak insurer. During contract negotiations, a reinsurer could require premium payments to be transmitted more frequently. After a contract becomes effective, a reinsurer could more closely monitor the financial condition of its ceding insurers. When a premium payment is not timely received, a reinsurer could immediately contact the ceding insurer to determine the reason for the late payment. A reinsurer might raise its rates to particular ceding insurers commensurate with increased risks, but such increases would likely be minimal in order to remain competitive with reinsurers adopting other risk-reducing strategies. And, of course, security is not necessary for reinsurance agreements between or among affiliates, in that they are under common ownership and control.

The "portion of any risk or obligation" language used in Code Section 922.2(a)(2) has not been judicially interpreted. The unique language plainly has a purpose more broad than to overcome the holding in *Pink*. Had overcoming *Pink* been the only purpose of the statute, the insolvency clause language in the Model Law used by the other states would have been followed when the credit for reinsurance statutes were revised in 1996, in that the purpose of the 1996 revision was to achieve greater uniformity among the states. Instead, the unique insolvency clause language used in former Code Section 922.2 was retained in Code Section 922.2(a)(2).

The Commissioner has determined that there are significant policy and regulatory reasons to deny financial statement credit for amounts that are subject to set-off in liquidation. The literal application of "the portion of the risk or obligation assumed" language in Code Section 922.2(a)(2) ensures full payment for credit given. The definition provided in this subdivision is the literal meaning of the words used in the statute, and there is no authority to provide a different meaning.

This subdivision is reasonably necessary to clarify that the words used in Code Section 922.2(a)(2) mean exactly what they state.

§2303.13(d) This subdivision provides that credit for a reinsurance agreement that is not subject to the requirements of Section 2303.13(a) shall be allowed if credit for the agreement

is permitted by the insurer's state of domicile. With respect to foreign insurers, Section 2303.13(a) is limited in application to the material reinsurance agreements of volume insurers. This subdivision is reasonably necessary to advise a foreign insurer that is not a volume insurer that credit will be allowed for reinsurance if permitted by its state of domicile. This subdivision is also reasonably necessary to advise volume insurers that as respects an agreement that is not a material reinsurance agreement, that credit will be allowed if permitted by the insurer's state of domicile. This subdivision is reasonably necessary for the efficient and effective enforcement of Code Sections 922.6 and 923.

§2303.13(e) This subdivision provides that credit for a reinsurance agreement of a domestic insurer may be allowed notwithstanding that the agreement does not meet the requirements of Section 2303.13(a) if the agreement involves multiple ceding insurers and either (1) the agreement is not a material reinsurance agreement and meets the requirements of the NAIC Accounting Guidance, or (2) the Commissioner has provided written consent to the claim for statement credit.

This subdivision is reasonably necessary to provide notice to a domestic insurer participating in a pooling agreement that is not in compliance with this section that it may claim statement credit for the reinsurance if the agreement is not a material reinsurance agreement and if the agreement meets the requirements of the NAIC Accounting Guidance. The subdivision is also reasonably necessary to provide notice to a domestic insurer participating in a pooling agreement that is not in compliance with this section that it may claim credit for a material reinsurance agreement with the Commissioner's written consent.

The subdivision also provides notice to a volume insurer participating in a pooling agreement, that if the agreement is a material reinsurance agreement it may claim credit for the reinsurance notwithstanding that the agreement is not in compliance with Section 2303.13(a), with the Commissioner's written consent.

The subdivision also provides notice of the procedure to follow to seek the Commissioner's consent to the subject transactions. The subdivision states that in reviewing applications for consent, the Commissioner shall consider both the business necessity for the agreement and the risk posed to the ceding insurer, its policyholders and creditors by the nonconforming provisions of the agreement.

This subdivision is reasonably necessary to permit credit for reinsurance that would otherwise not be allowed when an affected insurer is unable to obtain reinsurance in an agreement that meets the requirements of this section.

§2303.13(f) This subdivision provides that a denial of statement credit under this section shall be made in the manner prescribed in Section 2303.19(c) of this article. This subdivision is reasonably necessary for the efficient and effective enforcement of Code Sections 922.2(a)(2) and 923.

§2303.14 FORM OF AGREEMENTS

This section states form of agreement requirements applicable to the reinsurance agreements of licensees.

§2303.14(a) This subdivision specifies provisions that must be included within the reinsurance agreements of domestic insurers where statement credit is claimed for the cession. The subdivision specifies the sanctions for non-compliance as including a determination that the agreement is materially deficient under Code Section 717(d) in a license proceeding initiated pursuant to Code Section 701.

§2303.14(a)(1) This paragraph specifies that the agreement must include an insolvency clause provision which meets the requirements of Section 2303.13(b)(1) and (2) of this article. This requirement is necessary to make clear that a reinsurance agreement for which statement credit is claimed is deficient if it does not meet the requirements of Section 2303.13(b)(1) or (2) (where the sanction is denial of statement credit), and that the deficiency may cause the contract to be determined materially deficient under Code Section 717(d). This requirement is reasonably necessary to implement Code Section 717(d).

§2303.14(a)(2) This paragraph specifies that if the agreement includes a set-off provision, that it shall meet the requirements of Section 2303.13(b)(5) of this article. This requirement is necessary to make clear that a reinsurance agreement is deficient if it does not meet the requirements of Section 2303.13(b)(5) (where the sanction is denial of statement credit), and that the deficiency may cause the contract to be determined materially deficient under Code Section 717(d). This requirement is reasonably necessary to implement Code Section 717(d).

This paragraph also limits the scope of available offsets. It provides that a set-off provision must expressly list the items subject to set-off, which shall be limited to items arising from one or more reinsurance contracts between the same parties. In the event a court determines that the California insolvency clause does not by its terms preclude the application of a set-off to reduce a reinsurer's payment obligations to a domestic insurer in a liquidation proceeding, this provision is necessary to limit the scope of available set-offs that may be applied.

Code Section 1031 generally permits mutual debts and credits between two principals, such as an insurer and a reinsurer, to be set-off in a liquidation proceeding so that only the net balance due is paid. Unless set-off is limited to debts or credits arising from reinsurance contracts, a reinsurer could reduce sums it owed the insolvent insurer for policy claims by the amount the insolvent insurer owed it for, e.g., rent or consulting services. As explained in §2303.13(c) of this document, such set-offs preclude effective regulatory analysis of a company's true financial condition.

Moreover, unlimited set-offs present an opportunity for abuse by inflating sums due under contracts that are not subject to Department review. In groups of affiliated companies (where all members are under common ownership and control), one company will often assume most of the group's business and provide all services to members such as underwriting, claims handling, investments, etc., and also may lease real property or equipment to

members. Since many of the agreements are not subject to regulatory review, unlimited set-offs would allow inflated claims to reduce the lead company's payment obligations to a member company in liquidation. Since the group of insurers would control all the evidence, it would be difficult and costly for a liquidator to prove that fair value was not received for the amount claimed.

A regulator assessing a domestic insurer's financial condition has limited knowledge of the scope or amount of set-offs that may be applied to reduce a reinsurer's payments in the event of liquidation. Limiting the scope of permissible set-offs in liquidation is necessary to permit effective analysis of a statutory financial statement, to determine the true financial condition of a domestic insurer. This requirement is reasonably necessary to clarify and implement Code Sections 717(d) and 923.

This paragraph also provides that a set-off provision shall not contain language that deems items subject to set-off as "mutual" debts or credits. Code Section 1031 permits the set-off of mutual debts or credits. The statute does not define "mutual"; the determination of mutuality is made in the liquidation court. Parties cannot be permitted to circumvent a contrary ruling that may be issued in a liquidation court by "deeming" a debt or credit to be mutual. This requirement is reasonably necessary to clarify and implement Code Section 1031.

§2303.14(a)(3) This paragraph specifies that if the agreement contains an "extra contractual obligation" ("ECO'") provision permitting indemnity of the ceding insurer for damage awards arising from reinsured business but outside the coverage of the underlying policies, the provision shall permit indemnity only to the extent allowed by applicable law. This paragraph is limited in application to the reinsurance agreements of domestic ceding insurers claiming statement credit for the cession.

An ECO provision in a reinsurance agreement requires the reinsurer to indemnify the ceding insurer for a share of damage awards that may arise from reinsured business but outside the scope of the underlying policies. For example, ECO coverage would obligate the reinsurer to share in payment of an award made against the ceding insurer in a lawsuit brought by a policyholder for bad faith handling of a claim. An ECO provision is effectively first party liability coverage, with the reinsurer in the role of direct writer and the ceding company as the policyholder.

Code Section 533 states that an insurer may not be held liable for the "willful" acts of insureds. Although the statute does not define "willful", case law has interpreted the statute as precluding insurance coverage for acts that are inherently wrongful or committed with intent to harm. (*See*, e.g., *J.C. Penney Casualty Ins. Co. v. M.K.,* 52 Cal 3d 1009 (1991). Therefore, Code Section 533 would preclude coverage for some, but not all, acts that would be within the scope of an ECO clause. Unless the ECO clause is limited in scope, it could permit an insurer to be indemnified for its own willful wrong, contrary to California public policy. Therefore, the regulation permits ECO clauses in reinsurance agreements, if limited to the extent indemnity is allowed by applicable law. Such a limitation would permit a

reinsurer to decline to indemnify a domestic ceding insurer for damage awards precluded by Code Section 533.

The Commissioner has determined that a reinsurance agreement of a domestic ceding insurer is deficient if it does not limit the application of an ECO provision in a manner consistent with Code Section 533. to preclude provide for California jurisdiction. This regulation is reasonably necessary to interpret and implement Code Sections 533 and 717(d).

§2303.14(a)(4) This paragraph requires the agreement to include a jurisdiction provision specifying California jurisdiction. The paragraph is limited in application to the reinsurance agreements of domestic ceding insurers where statement credit is claimed for the cession. There is no jurisdiction requirement applicable to the agreement of a domestic insurer assuming business, in that jurisdiction over a reinsurance contract is generally in the state of the ceding insurer. In the event of a liquidation of a domestic ceding insurer, California jurisdiction to enforce the agreement will preserve estate assets by reducing or eliminating travel costs, and eliminate any need to retain out of state counsel. Prior to liquidation, California jurisdiction would generally be less expensive to a domestic insurer, reducing its operating costs.

The Commissioner has determined that a reinsurance agreement of a domestic ceding insurer is deficient if it does not provide for California jurisdiction. This regulation is reasonably necessary to interpret and implement Code Section 717(d).

§2303.14(a)(5) This paragraph requires the agreement to include a choice of law provision specifying California law. In the event of a liquidation of a domestic insurer, jurisdiction to enforce the agreement will be in California. It is most efficient for California law to be followed in such a forum, in that courts and counsel will be more familiar with California law.

The Commissioner has determined that a reinsurance agreement of a domestic ceding insurer is deficient if it does not include a choice of law provision specifying California law. This regulation is reasonably necessary to interpret and implement Code Section 717(d).

§2303.14(a)(6) This paragraph provides that if the agreement has an arbitration provision, it shall meet the requirements of Section 2303.13(b)(6) of this article. This requirement is necessary to make clear that a material reinsurance agreement is deficient if it does not meet the requirements of Section 2303.13(b)(6) (where the sanction is denial of statement credit), and that the deficiency may cause the contract to be determined materially deficient under Code Section 717(d). This requirement is reasonably necessary to implement Code Section 717(d).

This paragraph also requires an arbitration to be held in California, unless by mutual consent after a demand for arbitration has been made, the parties agree that arbitration may be held elsewhere. In the event of a liquidation of a domestic insurer, arbitration in California will preserve estate assets by reducing or eliminating travel costs, and eliminate the need to retain out of state counsel. Prior to liquidation, the parties may agree to hold arbitration elsewhere.

However, the provision requires that consent for arbitration outside of California must be made after a demand for arbitration is made. If consent is permitted at the time the agreement is negotiated, or prior to a demand for arbitration, the ceding insurer may be pressured to agree to arbitration outside of California notwithstanding increased cost and inconvenience.

The Commissioner has determined that a reinsurance agreement of a domestic ceding insurer is deficient if it requires arbitration to be held outside California. This regulation is reasonably necessary to interpret and implement Code Section 717(d).

§2303.14(a)(7) This paragraph specifies that a material reinsurance agreement for which a domestic ceding insurer claims statement credit is deficient if it does not meet the requirements of paragraphs (b)(2) through (b)(6) of this section. Subdivision (b) states requirements applicable to the material reinsurance agreements of volume insurers. The Commissioner has determined that a material reinsurance agreement for which a domestic ceding insurer claims statement credit is deficient if it does not meet the specified requirements, for the reasons stated in the sections relating to those requirements. This organization of requirements avoids duplicate text concerning the same subject, and is reasonably necessary to implement Code Section 717(d).

§2303.14(b) This subdivision specifies provisions that must be included within the material reinsurance agreements of domestic and volume insurers where statement credit is claimed for the cession. Limiting application of the subdivision to material reinsurance agreements reduces the compliance burden on insurers and the oversight burden on the Department. The subdivision specifies the sanctions for non-compliance as including a determination that the agreement is materially deficient under Code Section 717(d) in a license proceeding initiated pursuant to Code Section 701.

§2303.14(b)(1) This paragraph specifies that each agreement shall include an insolvency clause which, in substance, requires payment of the reinsurance by the reinsurer to the receiver, without diminution because of the insolvency of the ceding insurer, or because the receiver has failed to pay all or a portion of any claim. The NAIC Accounting Guidance requires all reinsurance agreements for which statement credit is claimed to include an insolvency clause. This paragraph applies only to foreign insurers and the requirement is consistent with the insolvency clause requirements of the other states. The Commissioner has determined that a material reinsurance agreement is deficient if it does not include an insolvency clause. This paragraph is reasonably necessary to provide one comprehensive checklist of required provisions to be included in the material reinsurance agreements of volume insurers. This paragraph is reasonably necessary to clarify and implement Code Sections 717(d) and 923.

§2303.14(b)(2) This paragraph specifies that the agreement shall meet the provisions of Section 2303.13(a) of this article, which sets forth the requirements for an "entire contract" clause. This requirement is necessary to make clear that a reinsurance agreement is deficient if it does not meet the requirements of Section 2303.13(a) (where the

sanction is denial of statement credit), and that the deficiency may cause the contract to be determined materially deficient under Code Section 717(d).

The Commissioner has determined that a material reinsurance agreement is deficient if it does not include the specified "entire contract" clause. This regulation is reasonably necessary to interpret and implement Code Section 717(d).

§2303.14(b)(3) This paragraph requires the agreement to provide that any change or modification shall be made only by written amendment signed by all parties. This requirement is necessary to reduce or eliminate disputes over contract amendments. In a liquidation proceeding, an insolvent company's records are often in disarray and key personnel are unavailable. Unless a change or modification to an agreement is formalized by written amendment signed by all parties, a liquidator may not have evidence to rebut a claim that a particular contract provision is not enforceable.

The Commissioner has determined that a material reinsurance agreement is deficient if it does not require formal amendment to change or modify the agreement. This regulation is reasonably necessary to interpret and implement Code Section 717(d).

§2303.14(b)(4) This paragraph provides that if an agreement contains an "early termination" provision wherein either party may terminate the agreement upon the occurrence of specified conditions, the basis for termination by the reinsurer may not include the entry of an order of rehabilitation, conservation or liquidation against the ceding insurer. This requirement is based on a requirement in the NAIC Accounting Guidance (SSAP 62:7), which provides that reinsurance contracts shall not permit entry of an order of rehabilitation or liquidation to constitute an anticipatory breach of the agreement.[2] Although the NAIC Accounting Guidance is contained in a section relating to property and casualty insurance, the Commissioner has determined that the rationale for the requirement is equally applicable to life and disability insurers and therefore should be applied to all licensees subject to this subdivision.

The application of the NAIC rule requires an *actual breach* by the ceding insurer, such as a failure to pay premium, rather than an *anticipatory* breach before the reinsurer may be relieved of its performance obligations. The NAIC rule addresses significant regulatory concerns. First, reinsurance on prospective business is absolutely critical to the chances for a successful rehabilitation. Second, even though the ceding company is in rehabilitation, it may well continue to perform its obligations under the contract, and it should not lose its reinsurance merely because a regulator has assumed control of the company. Third, the regulator should not be required to weigh the potential loss of reinsurance in making the

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[2] The NAIC and many states use the term "rehabilitation" to refer to the status of a company under formal regulatory control prior to liquidation. The California Insurance Code uses the term "conservation" instead of "rehabilitation," and the terms are used interchangeably in this document. (See, e.g., Code Section 922.2(a)(2) and 1016.)

determination of whether to seek a particular receivership order. Some receiverships are very complex and may include segregating estate assets and liabilities into different legal entities where the reinsurance of prospective business would be critical. A reinsurer can always terminate for non-performance if the ceding insurer fails to meet its obligations under the agreement.

This provision also provides that a reinsurer may not terminate the agreement except upon written notice of not less than sixty days, with signature required upon delivery of the notice. The loss of reinsurance may be catastrophic to a ceding insurer. The loss of reinsurance would affect various financial ratios and may require the company to stop writing new business. The company could quickly be in a hazardous financial condition if not insolvent. A ceding company would need at least sixty days notice in order to find replacement reinsurance.

The Commissioner has determined that a material reinsurance agreement of a ceding insurer is deficient if it permits termination by the reinsurer on the condition of the issuance of a receivership order, or permits termination by the reinsurer with a notice of less than sixty days. This regulation is reasonably necessary to interpret and implement Code Sections 717(d) and 923.

§2303.14(b)(5) This paragraph specifies that if the agreement provides for payments between the parties to be transmitted through an intermediary, the agreement shall include the following provision:

> "Payments by [the ceding insurer] to the intermediary shall be deemed to constitute payment to (the reinsurer). Payments by (the reinsurer) to the intermediary shall be deemed to constitute payment to (the ceding insurer] only to the extent that such payments are actually received by (the ceding insurer]."

Reinsurance intermediaries are licensed by the Department, however, the licensing requirements are minimal and require no Department oversight. (*See* Code Section 1781.1, *et seq*.) No federal or state regulator has ever examined a reinsurance intermediary. There is no requirement that they be independently audited, and none are independently audited. Intermediaries that are subsidiaries or divisions of holding companies or insurers may have their financial information included within audits of the parent company filed with the Securities and Exchange Commission, however, the intermediary operations are not separately audited. Intermediaries provide only unaudited financial statements to their clients.

Reinsurance intermediaries often provide services to the parties to a reinsurance agreement, including handling accounting, billing and transfer payments between the parties. All premium payments owed to the reinsurer are sent to the intermediary which then forwards the payments to the reinsurer. The reinsurer sends all payments for claims to the intermediary, which then forwards the payments to the ceding insurer. In providing these services, billions of dollars in transfer payments are handled annually by intermediaries.

There are no statutory requirements applicable to such transactions, and no limitations upon the length of time an intermediary is permitted to hold transfer payments. Although an intermediary has not failed recently, the possibility of failure exists in an area so minimally regulated.

When an intermediary holds payments from a ceding insurer, it is effectively holding assets included on the insurer's financial statement, until such time as the corresponding liability is reduced by payment to the reinsurer. The Commissioner cannot permit a ceding insurer's assets to be held for any length of time by a minimally regulated and unaudited entity. The Commissioner believes the better practice is to require the parties to transmit payments directly to one another, with notice to the intermediary. However, in recognition that such a policy may cause licensees to revise their accounting practices, the Commissioner has adopted the compromise used by some other states of allowing payments through the intermediary but transferring the risk to the reinsurer, notwithstanding that the intermediary is often the agent of the ceding insurer. The contract language required by the subject regulation transfers to the reinsurer the risk of an intermediary's failure or the risk of an intermediary's failure to transmit payment. The reinsurer can assess the financial strength and reputation of the intermediary and decide to either accept the provision in the contract or insist upon direct payment between the parties.

The Commissioner has determined that a material reinsurance agreement of a ceding insurer is deficient if it does not transfer the risk of intermediary transfer payments to the reinsurer. This regulation is reasonably necessary to interpret and implement Code Sections 717(d) and 923.

§2303.14(b)(6) This paragraph specifies escrow requirements that must be included in a material reinsurance agreement for use as an interim remedy when the ceding insurer contends that the reinsurer has breached the agreement because of a failure or refusal to pay amounts it claims is due. When the unpaid amounts reach specified levels, the regulation requires the establishment of an escrow account to hold the disputed payments pending resolution in a court proceeding or an arbitration of the issues that led the reinsurer to cease making payments.

The failure to receive timely payment from a reinsurer can have serious adverse effects upon the ceding insurer's financial stability or solvency. A ceding insurer that is deprived of substantial assets during arbitration proceedings or litigation, which may take a long time to resolve, can suffer significant cash flow problems that impact its ability to pay policyholders, and alter its financial ratios, causing it to restrict its writings of new business and increasing its risk of insolvency. The failure of a liquidation estate to receive timely payment can delay claim payments to policyholders and create cash flow problems for affected guarantee associations.

Moreover, without a requirement to pay disputed amounts into an escrow account, a reinsurer's unilateral decision to withhold significant reinsurance payments would give it undue financial leverage over a ceding insurer, potentially causing or worsening the ceding insurer's financial position. In such circumstances, ceding insurers may be forced to make

compromises or concessions regarding current and future reinsurance receivables, thus substantially reducing the financial benefit of the reinsurance contract. Further, without a requirement to pay disputed funds into an escrow account, the ceding insurer is exposed to an increased risk that the funds may not be collected at all; the reinsurer may become insolvent during the extended period of time the dispute is pending in arbitration or litigation.

This paragraph requires the reinsurer to safeguard the payment stream claimed due under the reinsurance contract while the underlying dispute is arbitrated or litigated. The establishment of an escrow account reduces the credit risk of the reinsurer's nonpayment and reduces the possibility of financial gain to the reinsurer through delaying payment.

A reinsurance agreement creates an undue risk to a ceding insurer if it permits a reinsurer financial incentive to delay payment, or increases the credit risk of non-payment by significantly extending the period of time before payment is required. An agreement that permits such undue risk is materially deficient. This paragraph is reasonably necessary to promote timely payment of reinsurance and to interpret and implement Code Section 717(d).

§2303.13(b)(6)(A) This subparagraph provides that within 60 days of the commencement of arbitration or litigation by either party, an escrow account shall be established if (1) the reinsurer has failed to pay an amount the ceding insurer contends is due without first obtaining an order from a court or arbitrator permitting denial or suspension of the payment, and (2) the aggregate unpaid amount equals or exceeds either 10% of the ceding insurer's policyholder surplus or 10% of the liquid assets of a ceding insurer that is in receivership, as reported on the ceding insurer's most recent financial statement.

The Commissioner has determined that unpaid reinsurance that equals or exceeds 10% of a ceding insurers policyholder surplus or 10% of the liquid assets of a liquidation estate is an amount sufficient to cause an adverse impact upon the insurer or the estate. An insurer not in liquidation could experience significant cash flow problems, causing it to delay claims payments to policyholders, and the impact upon its financial statements could require it to stop writing new business, exacerbating its financial stress. An insurer in liquidation has limited liquid assets to operate the estate and pay guaranty funds. In such circumstances, a ceding insurer or estate may be forced to make compromises or concessions regarding current and future reinsurance receivables, thus substantially reducing the financial benefit of the reinsurance contract.

The requirement that the escrow need not be established unless the amount in dispute equals or exceeds the 10% threshold limits the compliance burden to those disputes that involve significant risk or hardship to the ceding insurer or estate and to affected policyholders and creditors. Deferring the requirement to establish an escrow until 60 days after commencement of arbitration or litigation allows time to resolve the issues in dispute, and if unresolved, time to negotiate the terms of an escrow agreement. Further, requiring the commencement of arbitration or litigation as a prerequisite to establishing the escrow provides a forum in which the reinsurer can seek relief from the escrow requirement.

A reinsurance agreement creates undue risk to a ceding insurer if it allows the possibility that its benefits will be delayed or not received. An agreement that permits such undue risk is materially deficient. This subparagraph is reasonably necessary to reduce risk to a ceding insurer by promoting timely payment of reinsurance, and to interpret and implement Code Section 717(d).

§2303.13(b)(6)(B) This subparagraph requires the escrow to be established with a qualified financial institution as defined in Insurance Code section 922.7. This requirement is reasonably necessary to assure that, consistent with reinsurance trusts established pursuant to section 922.4, the funds are safeguarded by being held in a regulated, supervised financial institution meeting financial conditions established by the Commissioner or the Securities Valuation Office of the NAIC. This subparagraph is reasonably necessary to interpret and implement Code Section 717(d).

§2303.14(b)(6)(C) This subparagraph requires the reinsurer to deposit into an escrow account all accrued unpaid amounts, and subsequent unpaid amounts as they become due, except for those amounts where payment was allowed to be denied or delayed pursuant to an order of a court or arbitrator. This requirement is necessary to specify the amounts to be deposited into the escrow account, and is reasonably necessary to interpret and implement Code Section 717(d).

§2303.14(b)(6)(D) This subparagraph provides a forum for resolving disputes over the amounts claimed to be due as specified in the settlement reports. The majority of reinsurance agreements require disputes to be resolved by arbitration. An arbitration panel only has such authority as it is provided in the reinsurance agreement. This subparagraph is necessary to ensure that an arbitration panel has the necessary authority to review whether the net amounts claimed due from a reinsurer are reasonable. In the absence of this provision, a reinsurer would be without an interim remedy to challenge an amount claimed due on a settlement report if it believes the amount claimed is unreasonable. This subparagraph provides that the arbitration panel may hear such matters on an expedited basis. This requirement is necessary to prevent a ceding insurer from using the trust procedure to exert economic pressure over the reinsurer by requiring inflated sums to be deposited in the escrow account. This requirement is reasonably necessary to include within an escrow account procedure established for the stated purposes, and to interpret and implement Code Section 717(d).

§2303.14(b)(6)(E) This subsection states the specific requirements for the required escrow account. This subsection is reasonably necessary to provide standards that the Commissioner has determined are necessary to accomplish the purposes of the escrow, and to interpret and implement Code Section 717(d).

§2303.14(b)(6)(E)(i) This item provides that the escrow deposit must consist of cash or the investments permitted by Code Sections 1170 through 1182, which specify the type of assets that may be held by an insurer. Although payment to the ceding insurer is required to be in cash, it is reasonable to permit a deposit of other acceptable assets, in order to allow a greater return while the assets remain in escrow. This

item is reasonably necessary to provide standards that the Commissioner has determined are necessary to accomplish the purposes of the escrow, and to interpret and implement Code Section 717(d).

§2303.14(b)(6)(E)(ii) This item requires joint instructions from the ceding insurer and the reinsurer for withdrawals from the escrow account. This is a standard provision from escrow agreements. It is reasonably necessary to ensure that prior to resolution of the issues that are the subject of the litigation or arbitration, or upon resolution of those issues between the parties, that there is no dispute regarding the withdrawal of funds. This item is reasonably necessary to provide standards that the Commissioner has determined are necessary to accomplish the purposes of the escrow, and to interpret and implement Code Section 717(d).

§2303.14(b)(6)(E)(iii) This item requires periodic accounting by the escrow agent regarding the trust funds and provides that either the ceding insurer or the reinsurer may request an accounting. This is a standard provision used in escrow agreements, to allow the parties to monitor the account and the performance the escrow agent. This item is reasonably necessary to provide standards that the Commissioner has determined are necessary to accomplish the purposes of the escrow account, and to interpret and implement Code Section 717(d).

§2303.14(b)(6)(E)(iv) This item requires that the escrow agent's records shall be immediately available for inspection by the parties. This is a standard provision used in escrow agreements, to allow the parties to monitor the account and the performance of the escrow agent. This item is reasonably necessary to provide standards that the Commissioner has determined are necessary to accomplish the purposes of the escrow account, and to interpret and implement Code Section 717(d).

§2303.14(b)(6)(E)(v) This item governs distributions from the escrow and provides that the funds shall remain in the escrow until the matter in litigation or arbitration is finally resolved, unless the parties mutually agree to an interim distribution. Although this provision would permit a financially stressed ceding insurer impaired by an inadequate cash flow to perhaps negotiate a reduced payment for a valid claim, the provision is reasonably necessary to permit interim access to the funds in the event funds are held in escrow for an extended period. This item is reasonably necessary to provide standards that the Commissioner has determined are necessary to accomplish the purposes of the escrow account, and to interpret and implement Code Section 717(d).

§2303.14(b)(6)(E)(vi) This item provides that the escrow agreement must continue until all funds are distributed or withdrawn. This is a standard escrow provision. This item is reasonably necessary to provide standards that the Commissioner has determined are necessary to accomplish the purposes of the escrow account, and to interpret and implement Code Section 717(d).

§2303.14(b)(6)(E)(vii) This item provides that the escrow agent may resign only when a successor escrow agent is in place and the escrow funds have been

transferred. This is a standard escrow provision. This item is necessary to ensure that the funds remain in an escrow account which meets the requirements of this subdivision until such time as the escrow is properly terminated. This item is reasonably necessary to provide standards that the Commissioner has determined are necessary to accomplish the purposes of the escrow account, and to interpret and implement Code Section 717(d).

§2303.14(b)(6)(E)(viii) This item specifies the disposition of earnings of funds held in the escrow deposit, allowing the ceding insurer and reinsurer to take a proportion of the earnings equal to the proportion of their eventual distribution from the escrow. This item is necessary to prevent a party from gaining financial advantage by retaining all the earnings on the escrow deposit, regardless whether the party recovers any or all of the deposit. This item is reasonably necessary to provide standards that the Commissioner has determined are necessary to accomplish the purposes of the escrow account, and to interpret and implement Code Section 717(d).

§2303.14(b)(6)(F) This subparagraph provides that the reinsurer shall establish the escrow account and name the ceding insurer as a third party beneficiary if the ceding insurer is not a party to the escrow agreement. The obligation to establish the escrow account is made unilateral so that disputes between a ceding insurer and a reinsurer concerning the deposit or form of the escrow agreement do not prevent the escrow account from actually being established. The burden to establish the account is placed on the reinsurer because it is the party holding the disputed funds. The subparagraph also provides that by mutual agreement, the parties may include additional provisions that are not inconsistent with the form of agreement requirements of Section 2303.14(b)(5)(E). This subparagraph is reasonably necessary to provide standards that the Commissioner has determined are necessary to accomplish the purposes of the escrow account, and to interpret and implement Code Section 717(d).

§2303.14(b)(6)(G) This subparagraph requires the agreement to specify that depositing funds into the escrow account is an interim remedy and shall not excuse the reinsurer's obligation under the reinsurance agreement to make payment directly to the ceding insurer as payment becomes due. This subparagraph is necessary to clarify that the establishment of the escrow account is only an interim remedy and is not intended to provide the reinsurer with an alternate means of performance of its obligations under the reinsurance agreement. This subparagraph is necessary to prevent the escrow provisions from altering other terms of the agreement and to prevent a reinsurer from using the escrow provisions as a defense to a breach of contract claim by the ceding insurer. The subparagraph is reasonably necessary to provide standards that the Commissioner has determined are necessary to accomplish the purposes of the escrow account, and to interpret and implement Code Section 717(d).

§2303.14(c) This subdivision provides acceptable text to incorporate the escrow provisions into the agreement. An incorporation by reference of required provisions will reduce the compliance burden on licensees and the oversight burden on the Department. This subdivision is reasonably necessary to interpret and implement Code Section 717(d).

§2303.14(d) This subdivision specifies that the deposit of funds into an escrow account as required by this section is an interim remedy and may not be used as a defense in a proceeding brought against the reinsurer under Code Section 704. This subparagraph is necessary to prevent a reinsurer from using the escrow provisions of this section to shield conduct that would subject it to review or discipline by the Commissioner. This subdivision is reasonably necessary to interpret and implement Code Sections 704 and 717(d).

§2303.14(e) This subdivision specifies that the form of reinsurance agreements that are not subject to the requirements of subdivisions (a) or (b) of this section shall conform to the requirements of the NAIC Accounting Guidance. Subdivisions (a) and (b) do not apply to (1) the contracts of foreign insurers that are not volume insurers and (2) the contracts of volume insurers that are not material reinsurance agreements, and subdivision (b) does not apply to the contracts of domestic insurers that are not material reinsurance agreements. The subdivision also provides that each failure to comply with an NAIC requirement is a deficiency, and that one or more deficiencies may result in a determination that the agreement is "materially deficient" under Code Section 717(d). This subdivision is necessary to specify that the requirements of the NAIC Accounting Guidance are applicable to such agreements and the sanctions for non-compliance. This subdivision is reasonably necessary to interpret and implement Code Sections 717(d) and 923.

§2303.14(f) This subdivision provides that reinsurance agreements may contain additional provisions not inconsistent with the requirements of this article or the NAIC Accounting Guidance. This subdivision is reasonably necessary to interpret and implement Code Sections 717(d) and 923.

§2303.14(g) This subdivision provides that a reinsurance agreement not in compliance with the requirements of this section is not materially deficient if the Commissioner has provided written consent to financial statement credit for the cession pursuant to the provisions of Section 2303.13(e) of this article. Section 2303.13(e) relates to agreements including multiple ceding insurers, where a ceding insurer may not have control over the terms of the agreement, but nevertheless needs the reinsurance. If the Commissioner has consented to the agreement to permit statement credit, this subdivision clarifies that the agreement will not be found materially deficient pursuant to Code Section 717(d). This subdivision is reasonably necessary to interpret and implement Code Section 717(d).

§2303.15 OVERSIGHT OF REINSURANCE TRANSACTIONS

§2303.15(a) This subdivision provides that the policyholder surplus of a licensed insurer shall at all times be reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs, as determined by applying the factors set forth in Code Section 1215.5(f). The referenced section is within the Insurance Holding Company System Regulatory Act, codified in Code Section 1215, *et. seq*., which covers, *inter alia*, transactions among affiliated insurers, including reinsurance transactions..

The factors in Code Section 1215.5(f) are used to measure the adequacy of an insurer's policyholder surplus when considering the financial impact of an affiliate transaction. The

Code does not provide separate standards to measure the adequacy of the policyholder surplus of an insurer not within a holding company system. However, the factors included in Code Section 1215.5(f) are factors generally used by examiners in measuring the adequacy of an insurer's policyholder surplus. The subdivision is necessary to inform all affected parties of the standards used by the Commissioner to measure the adequacy of a licensee's policyholder surplus.

The subdivision also provides that reinsurance arrangements that result in a surplus below the required level are materially deficient under Code Section 717(d) and in violation of Code Sections 700(c), and are grounds for the sanctions permitted by Code Sections 701 and 1011. The Commissioner has determined that reinsurance arrangements that impact an insurer's policyholder surplus to such a degree that the surplus is below the level required by the application of the factors stated in Code Section 1215.5(f) are materially deficient. A licensee whose reinsurance arrangements are materially deficient does not meet the licensing requirements of Code Section 717. Code Section 700(c) requires a licensee to at all times meet licensing requirements. The subdivision is necessary to inform all affected parties of the consequences of reinsurance arrangements which result in a policyholder surplus below the required level.

The subdivision is reasonably necessary to interpret and implement Code Sections 700(c) and 717(d).

§2303.15(b) This subdivision provides definitions of terms used in this section. The definitions are necessary to avoid any ambiguity in the meaning or intent of the regulations. This subdivision is reasonably necessary to interpret and implement Code Section 717(d).

§2303.15(c) This subdivision defines a phrase used in Code Section 1011, a statute within an article of the Code that governs insurer receiverships. Code Section 1011 sets forth a wide variety of grounds for the Commissioner to obtain court-supervised receivership of a licensed insurer. The grounds include refusing to submit to examination; refusing to observe an order of the Commissioner to cure a deficiency in its capital; operating in a condition such that the further transaction of business would be hazardous to its policyholders, creditors or the public; wrongfully diverting assets; or failing to comply with the requirements for a license. The purpose of Code Section 1011 is to permit the Commissioner to place a licensed insurer into receivership if he believes it necessary to protect the insurer's policyholders, creditors or the public, to safeguard the insurer's solvency, or to preserve its assets.

Code Section 1011(c) authorizes the Commissioner to obtain receivership of a licensed insurer if, without first obtaining his consent, the insurer "has transferred, or attempted to transfer, substantially its entire property or business … or has entered into any transaction the effect of which is to merge, consolidate or reinsure substantially its entire property or business in or with the property or business of any other person." The Commissioner's prior consent to such a transaction is necessary to ensure that the transaction safeguards the solvency of the insurer and protects the interests of policyholders. For example, the Commissioner might need to forestall a transaction transferring 75% or more of a ceding insurer's liabilities to a reinsurer that was financially weak, or a transaction that forced

policyholders to release their rights against the transferor, without obtaining their informed consent.

Decades ago, seminal California appellate cases gave the Commissioner a sweeping scope of authority under Section 1011, construing the term "hazard" broadly to mean any "risk of loss to the policyholders," and holding that:

> "…(W)henever the commissioner deems the condition of a company hazardous, he should take over the company while these matters are being threshed out, …". (*Rhode Island Ins. Co. V. Downey* (1949) 95 Cal.App. 2d 220, 212 P.2d 965, 973, 980-81.)

However, the phrase, "substantially its entire property or business" used in Code Section 1011(c) is not defined in the Code, and has not been judicially interpreted. A definition of the phrase is necessary to avoid ambiguity in the application of the statute and to provide clarity and guidance for licensed insurers.

A similar phrase is used in the California Corporations Code relating to the sale of a corporation's assets, where the sale of "all or substantially all of its assets" must meet certain requirements in order to protect the interests of the shareholders. (See, e.g., Cal. Corp. Code Section 1001.) In *Jeppi v. Brockman & Holding Co*. (1949) 34 Cal.2d 11; 206 P.2d 847, the court considered the phrase, "all or substantially all of its assets," in a case involving the sale of corporate assets where the required shareholder consents were not obtained. The court explained the reason for the shareholder consent requirement at pages 15-16, as follows:

> "(A) corporation is organized for the purpose of doing business of some nature, and if so, its shareholders have the right to insist that the corporation continue for the purpose for which it was organized. A sale therefore, of all its property, or so much thereof as would prevent it from continuing in such business, would constitute a violation of the corporate contract." (Citation omitted; emphasis added.)

The *Jeppi* court emphasized that "(t)he provisions of the statute should not be applied solely upon the basis of the quantity of the property." (*Jeppi, supra* at p. 16). Although the "substantially all" analysis was not determinative of the issues in *Jeppi*, the case provides instruction on the appropriate measure to use in an analysis. The lesson from *Jeppi* is that the test of "substantially all" is not the quantity of property sold; rather the test is the impact of the sale on the corporation – whether the sale would prevent the corporation from continuing its business.

The rationale for shareholder consent to a sale of "substantially all" of a corporation's assets where the sale could prevent the corporation from continuing its business is not dissimilar to the rationale for Code Section 1011(c) in requiring the Commissioner's prior consent to an insurer's transaction of "substantially" its "entire … business." For an ordinary corporation, shareholder consent is sufficient to protect their interests, but for an insurer, the Commissioner's consent is necessary to safeguard the insurer's solvency and protect the interests of policyholders and creditors.

This subdivision defines the phrase, "substantially its entire property or business" to mean "an amount of business such that the sale, cession, assumption or purchase thereof has the potential to render a company insolvent or create a hazard to its policyholders or creditors." This definition is consistent with the *Jeppi* standard for determining what constitutes "substantially all" (whether the impact of the sale would prevent the corporation from continuing its business), because insolvency would prevent the insurer from lawfully carrying out its business. Moreover, it is consistent with the intent of Code Section 1011(c) and the holding in *Rhode Island*, to permit the Commissioner to initiate receivership, if he has not had an opportunity to review a transaction of a magnitude that could threaten a company's solvency or otherwise impair the interests of its policyholders.

The subdivision specifies that a sale, cession, assumption or purchase that equals or exceeds either 75% of an insurer's total premium or 75% of its total liabilities, calculated before the subject transaction, shall constitute "substantially its entire property or business" under Code Section 1011(c). When that much business is transferred, parties to the transaction experience significant impact on all aspects of their operations, including income, claims payments, assets and liabilities. Based on experience assessing the effects of transfers of insurance business between insurers over the course of several decades, the Commissioner has determined that a transaction involving 75% or more of an insurer's premium or liabilities is a transaction of such magnitude that it has the potential to render a company insolvent or create a hazard to its policyholders or creditors, and as such, requires his prior review and consent. In the review of such transactions, the Commissioner must ensure that the terms of the agreement meet statutory requirements, assess the financial strength of the other party to the agreement, and analyze the transaction to ensure that the impact of the agreement on the insurer's surplus shall at all times be reasonable in relation to the insurer's total liabilities and adequate to its financial needs, as determined by applying the factors set forth in Code Section 1215.5(f).

The subdivision also defines certain terms used in the definition, to avoid ambiguity in the application of the regulation.

The subdivision also states that it shall not be construed as limiting the scope of Code Section 1011(c), which includes transactions such as mergers in addition to the transactions covered in this article. The statute is phrased broadly, to include the entire array of possible types of insurance business transfers, in order to ensure that the statute's applicability will depend on the potential impact of the transaction on the insurer, rather than how the transaction was structured.

This subdivision is reasonably necessary to interpret and implement Code Sections 717(d), 1011(c) and 1011.5.

§2303.15(d) This subdivision specifies those insurers that are required to obtain the Commissioner's prior consent to transactions within the scope of subdivision (c) of this section. Although Code Section 1011(c) applies to all licensed insurers, this subdivision specifies that only domestic insurers and volume insurers need to obtain the Commissioner's

prior consent. This limitation is reasonably necessary in order to reduce the compliance burden on foreign insurers with minimal California business and to reduce the oversight burden on the Department. This subdivision is reasonably necessary to interpret and implement Code Sections 717(d), 1011(c) and 1011.5.

§2303.15(e) This subdivision advises insurers that are not subject to the filing requirement of subdivision (d) of this section that they need obtain the Commissioner's prior consent to a transaction within the scope of subdivision (c) only when directed to do so by notice from the Commissioner, and also that they may voluntarily seek the Commissioner's prior consent to the transaction. This subdivision is necessary to preserve the Commissioner's discretion to require a filing under Code Section 1011.5 when he believes review is necessary, and also to advise insurers not subject to the filing requirement that review of the transaction may be obtained upon application. This subdivision is reasonably necessary to interpret and implement Code Sections 717(d), 1011(c) and 1011.5.

§2303.15(f) This subdivision provides standards for consent to transactions within the scope of subdivision (c). Initially the subdivision provides that consent shall be based upon demonstrated business necessity. A cession or an assumption of business of 75% or more of a company's business has the potential to create a financial hazard or render a company insolvent. In a cession, assets and liabilities are transferred to another insurer, but the ceding company remains directly liability to policyholders. The ceding insurer takes the risk of the reinsurer's insolvency or failure to pay its share of the claims, leaving it without assets to pay its policyholders. In an assumption, where liabilities are assumed from the ceding insurer, the reinsurer takes the risk of adverse loss development (where losses exceed projections) as well as the ceding insurer's failure to remit premium or its insolvency. When a transaction is one of such magnitude that the failure of the other party to perform could cause an insurer's failure, it is reasonable to require the insurer to demonstrate an objective business necessity for the transaction. This requirement is reasonably necessary to implement and interpret Code Sections 717(d), 1011(c) and 1011.5.

The subdivision requires that licensed insurers shall maintain a significant level of risk, and that risk may be both direct and assumed. The function of an insurer is to bear insurance risk. The purpose of a license is subverted and the integrity of a license is diminished when an insurer does not bear significant risk. When an insurer transfers all but an insignificant amount of its risk to another insurer, the insurer is effectively performing the functions of an insurance agency or a managing general agent. The Commissioner has determined that it is appropriate for such entities to be licensed as brokers or managing general agents rather than as insurers. This requirement is reasonably necessary to implement and interpret Code Sections 717(d), 769.80, *et seq*., and 1621, *et seq*.

It is necessary to state a minimum retention level to provide a standard for use by licensees and Department staff to measure whether an insurer maintains "a significant level of risk." The Commissioner has determined that retention of 10% of premium on new direct business is an appropriate minimum retention level. Although 10% is a relatively small percentage, the amount is not insignificant. The subdivision provides that except for cessions to inter-company pools, consent to cessions of more than 90% of an insurer's total premium on

prospective business shall be given only for agreements with a limited contract term, generally not to exceed one year. The 90% calculation shall be applied to total premium, before the subject transaction. This requirement permits consent to a cession greater than 90% where the contract term is limited, if business necessity demonstrates the need. This requirement is reasonably necessary to interpret and implement Code Sections 717(d), 1011(c) and 1011.5.

Inter-company pools are excepted from the 10% retention requirement, in that the nature of a pool is that all members cede 100% to the pool and then share the risk of pool business through retrocessions. Subdivision (g) of this section states the requirements applicable to inter-company pools.

§2303.15(g) This subdivision states the conditions upon which the Commissioner will consent to inter-company pool agreements, where an insurer cedes 100% of its new business to a pool of affiliated insurers. The agreement must provide for a retrocession to the ceding insurer of an amount equal to not less than 10% of its new direct business. This retrocession percentage will result in the insurer bearing at least the minimum level of risk the Commissioner has determined necessary for an insurer to fulfill the function of its license.

Inter-company pool arrangements often permit the lead company in the pool to hold the majority of pool assets, with the member companies retaining only the minimum statutory capital and surplus required for initial licensing. In such arrangements, if the lead company fails, a member company will have insufficient assets to cover its obligations to its policyholders. In the past, these arrangements have caused considerable loss to California consumers and the California guarantee funds.

The Commissioner has determined that, in order to protect California consumers, it is reasonably necessary to require a member of an inter-company pool to maintain surplus at a level sufficient to cover its direct writings, or to require the lead insurer to provide security for the cession should its financial strength diminish during the term of the contract. The subdivision states that the Commissioner will not consent to an inter-company pool agreement unless either (1) the ceding insurer maintains surplus at a level sufficient to cover its direct writings, or (2) the agreement meets the requirements of subdivision (j) of this section that prescribes contract provisions for the conditional provision of collateral by the lead company in the pool. This requirement is reasonably necessary to protect California consumers and to interpret and make specific Code Sections 717(d), 1011(c) and 1011.5.

§2303.15(h) This subdivision identifies specific reinsurance transactions that the Commissioner has determined are so significant that his prior review and consent is necessary to ensure that the insurer's reinsurance arrangements are not materially deficient and that the insurer's solvency is protected. These are the reinsurance agreements with one party, where a domestic insurer or a volume insurer cedes or assumes an amount that is equal to or greater than 50% of its total business, but less than the 75% amount subject to the requirements of Code Section 1011(c) and Section 2303.15(c) and (d) of this section. When that much business is transferred, parties to the transaction experience significant impact on all aspects of their operations, including income, claims payments, assets and

liabilities. Based on experience assessing the effects of transfers of insurance business between insurers over the course of several decades, the Commissioner has determined that a transaction involving 50% or more of an insurer's premium or liabilities is a transaction of such magnitude that it has the potential to render a company insolvent or create a hazard to its policyholders or creditors, and as such, requires his prior review and consent. For several decades the Commissioner has reviewed these transactions under the authority of Code Section 1011(c). Although the potential impact of a 50% transaction on an insurer would fit within the definition of transactions subject to Code Section 1011(c), the sanction for non-compliance with the requirements of Code Section 1011(c) is conservation of the insurer. To avoid such a drastic remedy for a transaction involving a smaller percentage of business and a corresponding reduced risk of financial hazard or insolvency, the Commissioner has determined it appropriate to review such lesser transactions under the examination statutes, where he is permitted to conduct limited examinations as he determines necessary. The lesser sanction that would be applicable for non-compliance is appropriate for the reduced risk of hazard or insolvency.

Code Section 730 allows the Commissioner to define the nature, scope and frequency of an examination. The Commissioner has determined that a prior examination of a transaction is necessary when it has the potential to destabilize a company, create a financial hazard, or render it insolvent. The Commissioner must ensure that the reinsurance arrangements are not materially deficient under Code Section 717(d). Such a review includes a determination that the terms of the agreement meet statutory requirements, an assessment of the financial strength of the other party to the agreement, and an analysis to ensure that the impact of the agreement on the insurer's surplus shall at all times be reasonable in relation to the insurer's total liabilities and adequate to its financial needs, as determined by applying the factors set forth in Code Section 1215.5(f).

This subdivision is reasonably necessary to interpret and make specific Code Sections 700(c), 717(d), 730 and 736.

§2303.15(i) This subdivision provides instructions for the filings required by subdivisions (d), (e) and (h). To avoid any ambiguity that a duplicate filing may be necessary to comply with the filing requirements of Code Sections 1011.5 and 1215.5(b)(3) concerning specified reinsurance agreements, the subdivision provides that a filing made pursuant to subdivisions (d) or (e) of this section shall satisfy any filing requirements of those Code sections. This subdivision is reasonably necessary to interpret and make specific Code Sections 1011.5 and 1215.5(b)(3)

§2303.15(j) This subdivision specifies additional conditions to be met for the Commissioner's consent to a reinsurance transaction when his consent is required by this article or by Code Section 1215.5(b)(3). The subject transactions would be those where a domestic insurer or volume insurer cedes 50% or more of its business, or where a licensee cedes business to an affiliate. The subdivision provides that where the loss of statement credit for reinsurance ceded to a licensed or accredited reinsurer would cause a significant adverse impact upon a domestic or volume insurer, the Commissioner may condition consent to the transaction upon inclusion within the reinsurance agreement of a provision requiring

the reinsurer to provide security for the cession should its financial strength diminish during the term of the contract, or should a regulator deny credit for the cession.

The loss of statement credit for a cession of 50% or more of an insurer's business would generally be catastrophic to a ceding insurer, and likely render it insolvent. The financial strength of a reinsurer can change very quickly, depending on a variety of factors including its mix of business. Some reinsurers have been severely impacted by events such as 9/11 and increasingly frequent and severe hurricanes. In every cession of 50% or more of an insurer's business the Commissioner must evaluate the financial strength of the reinsurer. In cessions to an affiliate, the Commissioner must evaluate the financial strength of the group. Where the Commissioner determines that the nature of a transaction and the condition of the reinsurer may pose an undue risk of financial hazard or insolvency to the ceding insurer, it is reasonable to require the reinsurer to agree to provide security for its obligations under the contract, should its financial strength diminish. The subdivision permits the Commissioner to condition his consent to a transaction upon conditions that he believes are appropriate under the circumstances.

The subdivision specifies several financial measures that the Commissioner may require to be included in the contract as conditions requiring the reinsurer to provide collateral. The financial measures include a Risk Based Capital ratio of 200% of the authorized control level, and an A.M. Best strength rating of lower than B++. The Commissioner would not approve a 50% reinsurance agreement under this article or a cession to an affiliate under Code Section 1215.5(b)(3) if, at the time the Commissioner was reviewing the transaction, the reinsurer's financial strength was at the specified levels – unless the reinsurer agreed to collateralize its performance by providing the security specified in Code Section 922.5.

The subdivision also permits including the condition that the reinsurer will provide security for its obligations if financial statement credit would not be permitted by another state regulator without security for the cession. If another state regulator denies financial statement credit for the cession, the condition of the reinsurer would be such that it would be likely that the Commissioner would also deny financial statement credit. In such a circumstance, unless the reinsurer provided security for the cession, the ceding insurer would likely be rendered insolvent.

The subdivision requires the security to be provided to be in a form that meets the requirements of Code Section 922.5. This requirement is necessary to ensure that should the reinsurer's financial condition diminish to the point that statement credit would not be allowed for the cession, that the security provided would meet Code requirements to permit statement credit for the cession.

Requiring conditional security requirements in the agreement is reasonable in those cases where the Commissioner determines that the nature of the transaction and the condition of the reinsurer may pose an undue risk of financial hazard or insolvency to the ceding insurer without such security. This subdivision is reasonably necessary to interpret and make specific Code Sections 700(c), 717(d), 1011(c), 1011.5, and 1215.5(b)(3).

§2303.15(k) This subdivision states requirements for agreements where the contract is a material reinsurance agreement, the ceding insurer is either a domestic insurer or a volume insurer, and the agreement provides for transmission of payments between the parties through a reinsurance intermediary.

§2303.15(k)(1) This paragraph provides that the Commissioner may condition consent to the subject transaction upon the intermediary having been issued a satisfactory examination report by the Department.

The Department licenses reinsurance intermediaries, however, the licensing requirements are minimal and require no Department oversight. (*See* Code Section 1781.1, *et seq*.) No federal or state regulator has ever examined a reinsurance intermediary. There is no requirement that they be independently audited, and none are independently audited. Intermediaries that are subsidiaries or divisions of holding companies or insurers may have their financial information included within audits of the parent company filed with the Securities and Exchange Commission, however, the intermediary operations are not separately audited. Intermediaries provide only unaudited financial statements to their clients.

Reinsurance intermediaries often provide services to the parties to a reinsurance agreement, including handling accounting, billing and transfer payments between the parties. If an intermediary handles transfer payments, all premium payments a ceding insurer owes to the reinsurer are sent to the intermediary, which then forwards the payments to the reinsurer. The reinsurer sends all payments it owes the ceding insurer for claims to the intermediary, which then forwards the payments to the ceding insurer. In providing these services, billions of dollars in transfer payments are handled annually by intermediaries. There are no statutory requirements applicable to such transactions, and no limitations upon the length of time an intermediary is permitted to hold transfer payments. Although an intermediary has not failed recently, the possibility of failure exists in an area so minimally regulated.

The possibility of the failure of an unaudited and minimally regulated intermediary creates an undue risk for both the insurer and the reinsurer where the transfer payments are significant. The Commissioner has determined that where a material reinsurance agreement includes significant transfer payments through an intermediary, an examination of the intermediary may be necessary as a means of reducing risk to the parties.

Code Section 1781.10 permits examination of intermediaries by the Commissioner. Section 2303.17 of this article establishes intermediary examination procedures. The effective date of this particular subdivision (conditioning consent to transfer payments upon the existence of a satisfactory examination report) is delayed for one year after the effective date of Section 2303.17, to allow sufficient time for the initial intermediary examinations. This paragraph is reasonably necessary to interpret and make specific Code Section 717(d).

§2303.15(k)(2) This paragraph specifies the matters to be considered by the Commissioner in determining whether an examination report should be required. The paragraph specifies that the Commissioner shall consider the projected aggregate amount of

payments to be transmitted annually through the intermediary and the relative financial strength of the parties to the agreement. This paragraph allows the Commissioner to require an examination if he determines that the failure of the intermediary to transmit the projected amounts would adversely impact either party to the agreement. This paragraph is reasonably necessary to interpret and make specific Code Section 717(d).

§2303.15(k)(3) This paragraph provides that a satisfactory examination report must have an "as of" date of not more than 3 years prior to the date of the filing of the reinsurance agreement under review by the Department. This requirement is necessary to ensure that the examination report is reasonably current. This paragraph is reasonably necessary to interpret and make specific Code Section 717(d).

§2303.15(k)(4) This paragraph provides that, where an examination report has not been issued by the Department within 180 days of the intermediary's application for the examination, through no fault of the intermediary, the Commissioner may consent to the transmission of payments through the intermediary, subject to the subsequent receipt of a satisfactory examination report. Since the effective date of this subdivision is delayed for one year to allow time for the initial examinations of intermediaries, it is unlikely that an examination report would not be available at such time as this subdivision becomes effective. However, this provision is reasonably necessary to allow for the possibility that unforeseen circumstances may cause a delay in the issuance of an examination report. This paragraph is reasonably necessary to interpret and make specific Code Section 717(d).

§2303.15(l) This subdivision provides that if the parties desire to amend an agreement after the Commissioner has provided consent, the parties shall submit a copy of the proposed amendment to the Department at least 30 days prior to its execution for a determination of whether a new application for consent will be required. The subdivision requires that notice of the proposed amendment shall include an explanation of the reason for the change, and specifies the manner of submitting the notice. This subdivision is necessary to prevent the parties from changing the terms of an agreement in a manner that would have precluded the Commissioner's consent had the terms been included in the initial agreement. This subdivision is reasonably necessary to interpret and make specific Code Sections 700(c), 717(d), 923, 1011(c), and 1011.5.

§2303.15(m) After an insurer is issued a Certificate of Authority pursuant to Code Section 717, it is required by Code Section 700(c) to at all times comply with all requirements applicable to its license. This subdivision states requirements applicable to licensees that have been sold as a corporate shell, or when a sale of the insurer or other circumstance results in a significant change in the insurer's operations so that all or a majority of the documents previously submitted to the Department by the insurer concerning its operations are no longer valid.

Documents submitted by licenses pursuant to Code requirements include annual statements, actuarial opinions, audited financial reports, plan of operation, rate filings, policy form filings, service agreements, investment agreements, reinsurance agreements, biographical affidavits and fingerprint cards of officers and directors, articles of incorporation, by-laws,

etc. When those documents are no longer valid or current, the Department cannot confirm that the licensee meets licensing requirements, and as relevant here, cannot confirm that the insurer's reinsurance arrangements are not materially deficient. Code Section 730 permits the Commissioner to examine a licensee whenever he believes an examination is necessary. The Commissioner has determined that an examination of a licensee is necessary when all or a majority of the documents submitted to the Department by the insurer concerning its operations are no longer valid or current.

Code Section 730 allows the Commissioner to determine the nature and scope of an examination. In lieu of sending an examiner to the licensee's premises, the Commissioner has determined that it is less expensive for the licensee and more efficient for both the licensee and the Department for the licensee to submit specified documents to the Department for examination. This subdivision states the procedures and requirements applicable to such examinations. This subdivision is reasonably necessary to interpret and make specific Code Sections 700(c) and 717.

§2303.15(m)(1) This paragraph requires an insurer, within 60 days after a sale or other significant change in its' operations to submit for examination by the Department all documents the Department deems necessary to determine compliance with Code Section 700(c). The paragraph provides that, for good cause shown, the time to submit the required documents may be extended. This paragraph is necessary to state the time period within which compliance is required. This paragraph is reasonably necessary to interpret and make specific Code Sections 700(c) and 717.

§2303.15(m)(2) This paragraph specifies that a filing for a determination of compliance with Code Section 700(c) may be made in the manner set forth in Section 2303.22(h) of this article. The specific requirements for all filings required or permitted by this article are included in Section 2303.22. This paragraph is necessary to refer affected parties to that section. This paragraph is reasonably necessary to interpret and make specific Code Sections 700(c) and 717.

§2303.15(m)(3) This paragraph provides that the insurer may continue its operations while the examination is pending. This paragraph is necessary to inform an insurer under examination that it need not await notice from the Department in order to continue its operations. This paragraph is reasonably necessary to interpret and make specific Code Sections 700(c) and 717.

§2303.15(m)(4) This paragraph states the applicable burden of proof. On an application for a Certificate of Authority, amendment to a license, or when the licensee seeks the Commissioner's consent or approval, the burden is on the licensee to demonstrate compliance with applicable requirements, including that it is not materially deficient with any of the factors listed in Code Section 717. This subdivision provides that with respect a licensee not seeking an amendment to its license or other approval from the Department, the burden of establishing any material deficiency under Code Section 717 shall be on the Department. This paragraph is necessary to clarify that a licensee does not bear the burden of demonstrating compliance with Code Section 717 if it is not seeking the Department's

consent to amend its license or seeking other consent or approval required by the Code. This paragraph is reasonably necessary to interpret and make specific Code Sections 700(c) and 717.

§2303.15(m)(5) This paragraph states that notwithstanding the provisions of this subdivision, a licensed insurer shall not transact insurance, as that term is defined in Code Section 35, without first obtaining the approvals that may be required from the Department, such as prior approvals for rates or policy forms. Various activities of an insurer require prior approval by the Department. This paragraph is necessary to make clear that a licensee shall not transact insurance without first obtaining any required prior approvals. This paragraph is reasonably necessary to interpret and make specific Code Sections 700(c) and 717.

§2303.15(n) Occasionally the Commissioner requires a licensee to undertake an act that is to be performed at a future time. Such acts may include, for example, amending a reinsurance agreement at its next renewal to modify terms to comply with statutory requirements, or increasing the licensee's capital or surplus. This subdivision prescribes the form of formal commitments made by licensees. This subdivision is necessary to ensure that the form of a commitment is legally binding upon the licensee. This paragraph is reasonably necessary to interpret and make specific Code Sections 700(c) and 717.

§2303.15(o) This subdivision specifies the conditions when a formal report of examination shall issued by the Department. Code Section 730(a) allows the Commissioner to examine any licensed insurer whenever he deems it necessary. Code Section 730(b) permits the Commissioner to define the nature, scope and frequency of the examination. A formal examination of every licensed insurer is required not less frequently than once every five years. Such formal examinations generally take many months to complete. Code Section 734.1 prescribes the requirements for the formal written report of examination. Code Section 736 requires the licensed insurer to pay all examination costs.

The examinations required or permitted by this article are limited in scope and duration, and are undertaken to provide consent to a specific transaction. In carrying out its oversight function, the Department regularly examines the financial statements and other reports and information provided by licensees. Although Code Section 730(b) permits examinations that are limited in nature, scope or frequency, the Code does not prescribe the requirements for limited reports of examinations.

This subdivision clarifies that the formal report of examination required by Code Section 734.1, which are issued following once every five year formal examinations, will not be routinely issued for the limited examinations required or permitted by this article, or the limited examinations routinely performed as a function of Department oversight. A formal written report is not necessary in making the determination of whether to provide consent to a reinsurance transaction, nor is a formal written report necessary in the routine oversight examinations. Formal written reports of examination are very costly to produce and would be an unnecessary expense to the licensed insurer. The Commissioner has determined that it is reasonable not to issue such reports following examinations limited in scope, unless

requested to do so by the licensed insurer. The subdivision permits the insurer to request a formal written report of examination, with an acknowledgement that preparation of the report may require further examination of the insurer.

This subdivision is reasonably necessary to clarify and make specific Code Sections 700(c), 717(d), 730, 734.1, and 736.

§2303.15(p) This subdivision provides that the Commissioner's consent is conditioned upon the truth and veracity of the documents and information submitted by or on behalf of the licensed insurer making the request. The subdivision states the consequences for submitting documents or information that are materially false or misleading, or failing to disclose material information, as including voiding of consent and revocation of a Certificate of Authority.

This subdivision is necessary to ensure the truth and veracity of documents and information submitted by a licensee to gain the Commissioner's consent. This subdivision is reasonably necessary to clarify and make specific Code Sections 700(c), 701, 717, and 1011.5.

§2303.16 ATTESTATION REQUIREMENTS

This sections states requirements for information that insurers must include with their annual financial statements. Financial statements are to be filed in a form and manner specified by the Commissioner. (*See*, Insurance Code section 900) Pursuant to Insurance Code section 923, insurers are required to prepare their annual financial statements using the following:

> " ... statement blanks [forms] and instructions thereto ... adopted by the National Association of Insurance Commissioners. The statement shall be completed in conformity with the Accounting Practices and Procedures Manual adopted by the National Association of Insurance Commissioners, to the extent that the practices and procedures contained in the manual do not conflict with any other provision of this code. The commissioner may make changes from time to time in the form of the statements ... as seem to him or her best adapted to elicit from the insurers a true exhibit of their condition ..." (California Insurance Code section 923)

In 2004, regulators discovered that "side agreements" had been used by some property and casualty insurers to reduce or avoid the transfer of insurance risk in reinsurance agreements. The use of side agreements was discovered in the investigation of the insurance industry conducted by New York Attorney General Elliot Spitzer. In evaluating risk transfer, a regulator needs to review all agreements between the parties to determine whether any provision may limit the amount of insurance risk to which the reinsurer is subject under the agreement, or delay the timely reimbursement of claims by the reinsurer. (*See*, e.g., SSAP 62:11.) By use of side agreements hidden from the Commissioner and other regulators, some reinsurance agreements that appeared to transfer risk, were effectively financing arrangements that transferred no risk to the reinsurer.

The NAIC moved quickly to address the issue. Commencing with the annual statement for 2005, each property and casualty insurer is required to file with its annual statement a form

designated as "Supp 20-1," titled "Reinsurance Attestation Supplement," which requires an insurer's Chief Executive Officer and Chief Financial Officer to make four attestations, under penalty of perjury, including (in pertinent part) the following:

> "(1) Consistent with *SSAP No. 62 - Property and Casualty Reinsurance*, there are no separate written or oral agreements between the reporting entity [insurer] (or its affiliates or companies it controls) and the assuming insurer that would under any circumstances, reduce, limit, mitigate or otherwise affect any actual or potential loss to the parties under the reinsurance contract ...
> ...
> Any exceptions to the aforementioned shall be disclosed in the attestation and an explanation of the exceptions shall be attached to the attestation."

However, the separate agreements disclosed in the NAIC attestation supplement may not be sufficiently identified to allow the Commissioner to match the separate agreements disclosed with the reinsurance agreements to which they relate. This section requires that for each separate agreement disclosed in the NAIC attestation form, the insurer shall provide a summary description of the separate agreement, including the parties, the date of execution and the inception date, and a summary description of the agreement to which the separate agreement relates, including the parties, the date of execution and the inception date. The section provides that the additional information may be included within the NAIC attestation form or as an attachment thereto.

This information will allow the Commissioner to make a determination whether review of the separate agreements disclosed is necessary. If the Commissioner determines that a separate agreement disclosed has already been reviewed by the Department in conjunction with the risk transfer analysis of the related reinsurance agreement, further review of the separate agreement is not necessary. The Commissioner could also determine that review is not necessary because the separate agreement relates to an agreement that is not a material reinsurance agreement.

The section also provides that by notice to licensees with the Annual Statement Instructions, the Commissioner may waive the supplemental filing required by this section, or otherwise limit or further define the information to be provided. The NAIC disclosure requirement may change, as the NAIC further considers and responds to this issue. In the event the NAIC revises the disclosure requirement, this provision would permit the Commissioner to waive the requirements of this section or further limit or define the information to be provided. Without this notice provision, the timing of the NAIC change could result in a lack of uniformity with NAIC requirements if a change in the California disclosure requirement had to be delayed until such time that the regulation is formally amended.

This section is reasonably necessary to clarify and make specific the risk transfer requirement of Code Section 922.3, and the financial reporting requirements of Code Section 923.

§ 2303.17 REINSURANCE INTERMEDIARIES

This section establishes the standards and procedures for the examination of a licensed reinsurance intermediary as permitted in Code Section 1781.10. Reinsurance intermediaries are licensed by the Department pursuant to Code Section 1781.1, *et seq*. The licensing requirements are minimal, and except for examination at the discretion of the Commissioner, no Department oversight of intermediaries is required.

In addition to assisting insurers in negotiating reinsurance agreements, reinsurance intermediaries often provide services to the parties, including accounting, billing, and transfer payments. If an intermediary handles transfer payments, all premium payments a ceding insurer owes to the reinsurer are sent to the intermediary, which then forwards the payments to the reinsurer. The reinsurer sends all payments it owes the ceding insurer for claims and loss adjustment expenses to the intermediary, which then forwards the payments to the ceding insurer. In providing these services, billions of dollars in transfer payments are handled annually by intermediaries. There are no statutory requirements specifically applicable to such transactions, and no limitations upon the length of time an intermediary is permitted to hold transfer payments.

No federal or state regulator has ever examined a reinsurance intermediary. There is no requirement that a reinsurance intermediary broker be independently audited, and none are independently audited; they provide only unaudited financial statements to their clients. Intermediaries that are subsidiaries or divisions of holding companies or insurers may have their financial information included within audits of the parent company filed with the Securities and Exchange Commission; however, the intermediary operations are not separately audited. Although an intermediary has not failed recently, the possibility of failure exists in an area so minimally regulated.

The possibility of the failure of an unaudited and minimally regulated intermediary creates an undue risk for both the insurer and the reinsurer where the transfer payments are significant. The Commissioner has determined that where a material reinsurance agreement includes significant transfer payments through an intermediary, an examination of the intermediary may be necessary to better evaluate the risk to the parties of the transfer payment arrangement. Section 2303.15(k) of this article provides that the Commissioner may condition consent to specified transactions involving significant transfer payments upon the intermediary having been issued a satisfactory examination report by the Department.

This section specifies the procedures for the examination of a licensed intermediary. The Code is silent on the conduct of the intermediary examinations permitted by Code Section 1781.10. The Commissioner has determined that it is reasonable to follow the examination procedures specified in Code Section 730 et. seq. which apply to the examination of insurers, to the extent they may be appropriate for the examination of intermediaries. This section is reasonably necessary to interpret and make specific Code Section 1781.10.

§2303.17(a) This subdivision provides that an application for examination of an intermediary may be made upon the request of the intermediary, or upon the request of a

licensed insurer with the written consent of the intermediary. The subdivision specifies the documents to be included with the application, including copies of the financial reports provided by the intermediary to its clients in the three years prior to the application; copies of specified financial reports if the intermediary is not independently audited; a report of funds held in fiduciary accounts; a description of fidelity bonds and errors and omission policies; and other information as may be requested by the Commissioner. The information required by this subdivision is the minimum information necessary to commence an examination of the financial affairs of an intermediary. This subdivision is reasonably necessary to interpret and make specific Code Section 1781.10.

§2303.17(b) This subdivision provides that each financial report submitted pursuant to this section shall be certified by an officer of the intermediary as being a true copy of the original, and shall contain a statement signed by the intermediary's chief financial officer under penalty of perjury attesting to the veracity of the report. The subject financial reports are not independently audited. This requirement is reasonably necessary to ensure the accuracy and veracity of the submitted financial reports. This subdivision is reasonably necessary to interpret and make specific Code Section 1781.10.

§2303.17(c) This subdivision states that the Commissioner shall examine the business and affairs of the intermediary to determine its compliance with applicable provisions of the California Insurance Code and its ability to fulfill its obligations. This subdivision is reasonably necessary to specify the scope and purpose of the examination, which follow similar requirements applicable to the examination of insurers in Code Section 733. This subdivision is reasonably necessary to interpret and make specific Code Section 1781.10.

§2303.17(d) This subdivision specifies the procedures for issuance of the examination report, which follow similar requirements in Code Section 734.1 applicable to the issuance of examination reports for insurers. This subdivision provides that following completion of the examination, the Department shall provide the intermediary with a copy of the examination report, together with a notice that the intermediary has 30 days to make a written submission or rebuttal with respect to any matters contained within the examination report. Within 30 days after expiration of the time to respond, the Commissioner shall fully consider the examination report and any responsive submissions by the intermediary and either adopt the examination report as prepared by the examiner or with modifications or corrections, or reject the examination report and require re-opening of the examination for purposes of obtaining additional information.

These requirements are reasonably necessary to provide the intermediary with an opportunity to respond to information within the examination report before the Commissioner issues the final report. This subdivision is reasonably necessary to interpret and make specific Code Section 1781.10.

§2303.17(e) This subdivision provides that in conducting the examination, the Commissioner shall observe those guidelines and procedures set forth in the Examiner's Handbook adopted by the NAIC as may be relevant to the examination of an intermediary, and may employ other guidelines or procedures which he deems appropriate. Since federal

or state regulators have never examined reinsurance intermediaries, there are no established procedures to follow in conducting the examination. This subdivision is necessary to permit the development of appropriate examination procedures, following established guidelines for the examination of insurers.

The subdivision also provides that all documents disclosed in connection with the examination may be used by the Commissioner and shall be given confidential treatment by the Commissioner to the same extent as provided in Code Section 735.5 for documents disclosed in connection with the examination of insurers. This subdivision is necessary to give appropriate protection to the documents disclosed to the Department in connection with an intermediary examination, to the same extent as the protection given to the documents disclosed in connection with the examination of an insurer.

This subdivision is reasonably necessary to interpret and make specific Code Section 1781.10.

§2303.17(e) This subdivision specifies that the Commissioner shall not commence examination of the intermediary until receipt of a written commitment from the applicant, satisfactory to the Commissioner, that the applicant shall promptly pay all costs of the examination. Code Section 1781.10, which permits examinations of intermediaries, is silent on the question of payment for the examination. However, Code Section 736 expressly states, "all examinations shall be at the expense of the insurer, organization or person examined." Code Section 19 defines "person" as meaning "any person, association, organization, partnership, business trust, limited liability company, or corporation", which would include a reinsurance intermediary. This subdivision is reasonably necessary to ensure that the Department is promptly reimbursed for the costs of the examination, and to interpret and make specific Code Section 1781.10.

§2303.17(f) This subdivision provides that a request for an examination of a reinsurance intermediary shall be made following the procedures set forth in Section 2303.22(i) of this article. This subdivision is reasonably necessary for the efficient organization of this article to provide one section which states the requirements for all filings required or permitted by this article. This subdivision is reasonably necessary to make specific Code Section 1781.10.

§2303.17(g) This subdivision requires licensed intermediaries to annually file with the Department a copy of the financial statements they provide to their clients pursuant to the requirements of Code Sections 1781.6(c) and 1781.9(b). Receipt of copies of these financial statements will allow the Department to monitor an intermediary's financial condition in the years following examination, and aid in the determination of whether a further examination of the intermediary is required. This subdivision is reasonably necessary to clarify and make specific Code Section 1781.10.

§2303.17(h) This subdivision provides that nothing herein shall preclude the Commissioner from examining an intermediary whenever he deems necessary. Code Section 1781.10 provides that an intermediary "shall be subject to examination by the commissioner." No limitation is stated. This subdivision is necessary to make clear that an

examination of an intermediary may be conducted at the Commissioner's discretion, notwithstanding that an examination has not been requested pursuant to subdivision (a) of this section. This subdivision is reasonably necessary to clarify and make specific Code Section 1781.10.

§ 2303.18 COMMISSIONER'S DISCRETION

This section provides that the Commissioner may exercise discretion in requiring strict compliance with the requirements of this article, where the Commissioner determines that (1) the variance is not material, (2) the true financial condition of the insurer may be elicited from analysis of the financial statements and other public documents as may be filed, and (3) compliance would cause undue hardship to the insurer.

Reinsurance accounting and arrangements are often exceedingly complex, and circumstances may arise where a particular regulation may have an unforeseen and unintended negative consequence for a licensee. This section is reasonably necessary to allow the Commissioner to exercise discretion in requiring strict compliance with the regulations in exceptional circumstances. The Commissioner's discretion is limited by the necessity to make a determination that, (1) the variance is not material, (2) the true financial condition of the insurer may be elicited from analysis of the financial statements and other public documents as may be filed, and (3) compliance would cause undue hardship to the insurer. This regulation is reasonably necessary to interpret and implement Code Sections 700(c), 717(d) and 923.

§ 2303.19 DENIAL OF STATEMENT CREDIT AND NON-ADMISSION OF ASSETS

This section specifies the manner that credit for reinsurance will be denied, and the procedures applicable to issuing such denials. The section also specifies a procedure for review of the Commissioner's denial of financial statement credit and clarifies that this section is not a limitation on the Commissioner's authority to require other adjustments to financial statements as may be required by the NAIC Accounting Guidance.

§2303.19(a) This subdivision provides that credit on financial statements for reinsurance ceded shall be denied if the applicable requirements of Sections 2303.3 through 2303.13 of this article have not been met, by non-admission of recoverables on paid losses, disallowance of recoverables on unpaid losses, or a requirement to use deposit accounting for the cession.

Credit for reinsurance is claimed on financial statements in various types of accounting entries prescribed by the NAIC Accounting Guidance. This subdivision specifies the standard accounting entries required when credit is not permitted. This subdivision is reasonably necessary to clarify and make specific the provisions of Code Section 923. This subdivision is reasonably necessary to make specific Code Sections 922.2, 922.3, 922.4, 922.5, 922.6 and 923.

§2303.19(b) This subdivision provides that reinsurance recoverables that are due more than 90 days from a reinsurer to a domestic insurer on paid losses or paid loss adjustment expenses may, in the Commissioner's discretion, be deemed non-admitted assets, which is a denial of statement credit for the reinsurance. The non-payment within 90 days of reinsurance recoverables on paid losses or paid loss adjustment expenses occurs when the reinsurer disputes its obligation to make the payment. If the dispute must await resolution in arbitration or litigation, the sum claimed due by the ceding insurer may not be paid for years, if at all.

Requiring a recoverable due more than 90 days to be reported as a non-admitted asset is more restrictive than the corresponding instruction in the NAIC Accounting Guidance, which permits unpaid recoverables on paid losses to be reported as admitted assets for an extended period of time. Code Section 923 requires licensed insurers to comply with the NAIC Accounting Guidance, to the extent it is not in conflict with the Code. Code Section 923 permits the Commissioner to change the NAIC financial statement requirements as he believes necessary to elicit from an insurer a true exhibit of its financial condition.

Statutory financial statements are intended to provide a conservative representation of an insurer's financial condition. Reporting recoverables unpaid for more than 90 days as assets when they may not be collected is inconsistent with the conservative requirements of statutory accounting. Moreover, the denial of statement credit for recoverables that are not paid promptly is appropriate under Code Section 922.3, in that late payment of reinsurance violates the fundamental accounting rules of risk transfer for claiming statement credit. This subdivision is necessary to clarify and make specific that the Commissioner may exercise his discretion to require such reinsurance recoverables to be reported as non-admitted assets when he believes the credit taken for the reinsurance is not warranted under Code Sections 922.3 or 923.

The subdivision is applicable only to domestic insurers, in deference to the reporting requirements of the other states. It would be a hardship upon a foreign insurer to prepare a financial statement to comply with more restrictive California requirements and another statement conforming to the requirements of its state of domicile. In recognition that foreign insurers may prepare their financial statements with less restrictive requirements, the subdivision provides that a domestic insurer may follow the NAIC Accounting Guidance when reporting reinsurance recoverables due more than 90 days on its financial statements, unless the Commissioner expressly requires the statements to reflect the subject recoverables as non-admitted assets. This provision is necessary to allow domestic ceding insurers to remain competitive with foreign insurers that need only comply with the NAIC Accounting Guidance.

The NAIC Accounting Guidance permits a ceding insurer to make an election as to whether to claim financial statement credit for an unpaid reinsurance recoverable. It is in the insurer's interest to claim the credit, since foregoing the credit would likely result in a change in its financial ratios, triggering a variety of adverse consequences such as restricting its writings of new business or lowering its financial strength ratings. The NAIC Accounting Guidance requires the credit to be reduced over time, but permits a credit to be claimed for an extended

period. In recognition of the competitive advantage that would be gained by foreign insurers, the Commissioner has determined that it is reasonable to permit a domestic insurer to follow the NAIC Accounting Guidance, and to adjust its financial statements to reflect the unpaid recoverables as non-admitted assets only when he expressly requires it to do so.

If the Commissioner determines that credit taken for reinsurance recoverables on paid losses and paid loss adjustment expenses may not be warranted, he may informally request a domestic insurer to restrict its writings or take other appropriate action to safeguard its solvency, without requiring a change in its financial statements. Such an informal requirement would permit the domestic insurer to remain competitive with foreign insurers operating under the less restrictive standard of the NAIC Accounting Guidance. If, however, the Commissioner determines that the unpaid recoverables are likely not collectible or an extended delay in payment warrants a change in the insurer's financial statements, this subdivision makes clear that the Commissioner may require the financial statement to reflect the recoverables as non-admitted assets, notwithstanding a different requirement in the NAIC Accounting Guidance.

This subdivision is reasonably necessary to clarify and make specific the requirements of Code Sections 922.3 and 923.

§2303.19(c) This subdivision provides that upon a determination that credit for reinsurance ceded shall not be permitted or an asset is deemed non-admitted, the Commissioner shall issue a finding in the form of a written explanation to the ceding insurer setting forth the reasons for the determination. The determination may be appealed to the Chief of the Financial Surveillance Branch or to the successor position after a reorganization of the Department, in a manner consistent with making a request for a permitted accounting practice.

This subdivision is intended to provide a ceding insurer with a written statement of the reasons for the Commissioner's determination and an appeal process. If the determination was based on the specifics of a transaction, a written statement of reasons would permit the insurer to evaluate whether the transaction could be restructured in order to permit statement credit. A written statement of the basis for the determination would permit the ceding insurer to determine whether it wishes to seek further review of the matter by filing an appeal with Commissioner's Chief of the Financial Surveillance Branch. (The Financial Surveillance Branch is a unit within the Department of Insurance responsible for examination and review of all insurers conducting business in California. It is the Branch that would have reviewed the reinsurance transaction and have denied the statement credit.)

The subdivision also provides that the appeal is to be submitted in a manner consistent with making a request for a permitted accounting practice. A request for a permitted accounting practice is a standard procedure in the insurance industry whereby an insurer seeks to obtain a waiver from a regulator of applicable accounting rules. A permitted practice request is submitted in the form of a letter which explains the reason the waiver or variance is necessary or justified, accompanied by whatever documentation the insurer would like to have considered.

This subdivision is reasonably necessary to clarify and make specific Code Sections 922.2, 922.3, 922.4, 922.5, 922.6, and 923.

§2303.19(d) This subdivision provides that denial of credits on financial statements for reinsurance ceded pursuant to subdivisions (a) and (b) of this section shall not be construed to be the only adjustments for reinsurance contemplated under the California Insurance Code. To the extent that the NAIC Accounting Guidance prescribes additional reductions in credits for reinsurance or additional liability provisions for reinsurance, the NAIC Accounting Guidance shall be followed.

This subdivision is necessary to clarify that ceding insurers are required to follow the NAIC Accounting Guidance, as required by Code Section 923, and to the extent that it provides for other adjustments in financial statements, that those provisions continue to apply. This subdivision is reasonably necessary to clarify and make specific Code Section 923.

§ 2303.20 SANCTIONS FOR NON-PAYMENT OF REINSURANCE

This section states conditions where sanctions may be imposed upon a reinsurer for its failure to make timely payment of obligations due under a reinsurance contract, when it is without sufficient justification to deny or delay payment.

A ceding insurer has an obligation to pay policy claims and loss adjustment expenses whether or not it is indemnified by a reinsurer for its share of those payments. Under the terms of the reinsurance agreement, the ceding insurer would have transferred to the reinsurer some or the entire premium received on the policies reinsured in exchange for the promise of indemnification of all or a specified share of the losses and loss adjustment expenses. When the reinsurer does not promptly indemnify the ceding insurer for its share, the ceding insurer's cash flow is adversely affected, placing a strain on its ability to continue to pay claims. When the unpaid amount is significant and the delay is over an extended period, the loss of statement credit for the reinsurance and the resulting change in the ratios on its financial statements could require the ceding insurer to stop writing new business, exacerbating its financial stress. In such circumstances, notwithstanding the validity of its claim for payment, a ceding insurer may be forced to make compromises or concessions regarding current and future reinsurance receivables, thus substantially reducing the financial benefit of the reinsurance contract. The compromise or concession may stave off imminent insolvency, but the loss of the benefit of the reinsurance agreement would likely leave the ceding insurer in a financially impaired condition. If payment of a significant amount of valid claims is delayed over an extended period while arbitration or litigation is pending, a ceding insurer may become insolvent.

When such dire consequences to the ceding insurer can result from a reinsurer's decision to deny or delay payment of sums claimed due under a reinsurance contract, a reinsurer's refusal to make timely payment must be made in good faith. Code Section 704 provides, in pertinent part:

> The commissioner may suspend the certificate of authority of an insurer for not exceeding one year whenever he finds, after proper hearing following notice, that such insurer engages in any of the following practices:
> …
> (b) Not carrying out its contracts in good faith….

This section construes the term "not carrying out its contracts in good faith" in the context of a failure or refusal to pay reinsurance obligations. The section is intended to promote the timely payment of valid claims by providing sanctions for the arbitrary denial or delay of payments claimed due. This section is reasonably necessary to interpret and make specific Code Sections 704 and 704.7.

§2303.20(a) This subdivision specifies that the failure or refusal of a reinsurer to make payments to a ceding insurer of the amount shown on a settlement report as the reinsurer's share of losses and loss adjustment expenses shall constitute not carrying out a contract in good faith under Code Section 704 if the reinsurer's response to the settlement report does not establish that it had a reasonable basis for its decision.

A reinsurer is bound by the terms of the reinsurance agreement to make timely payment to the ceding insurer of the net amount shown due on a settlement report. Consistent with its obligation to carry out its contracts in good faith, if a reinsurer refuses to make timely payment, it must be required to objectively demonstrate a factual basis supporting its decision to deny or withhold payment. Consistent with its obligation to carry out its contracts in good faith, if the reinsurer claims that an investigation of a claim is necessary, it must be required to demonstrate an objective need for additional information. Consistent with its obligation to carry out its contracts in good faith, as soon as sufficient additional information is obtained in the investigation to make a determination, the reinsurer must be required to either pay the claim or have sufficient evidence to support a denial.

This subdivision also specifies that the failure or refusal of a reinsurer to make payments to a ceding insurer of the amount shown on a settlement report as the reinsurer's share of losses and loss adjustment expenses shall constitute not carrying out a contract in good faith under Code Section 704 if the reinsurer's investigation of the ceding insurer's claim for payment was not conducted in good faith. An investigation conducted in good faith would be one pursued without delay and seeking only relevant information.

Without these requirements, a reinsurer could fail to honor the terms of the contract for improper reasons, such as to exert leverage or pressure over the ceding insurer, or to preserve its own cash flow to the detriment of the ceding insurer. This subdivision is reasonably necessary to interpret and make specific Code Section 704.

§2303.20(b) This subdivision defines "settlement report" and "timely payment", which are key terms used in the section. This subdivision is reasonably necessary to avoid ambiguity in the meaning of the terms used. This subdivision is reasonably necessary to interpret and make specific Code Section 704.

§2303.20(c) This subdivision specifies sanctions that may be applied for a violation of Code Section 704.

Code Section 704.7 provides that in a proceeding under Code Section 704 for an insurer's failure to carry out its contracts in good faith, the Commissioner may issue an alternative order that permits an insurer to pay a fine up to $55,000 in lieu of having its certificate of authority suspended. Section 704.7 provides that the fine pertains to " ... a proceeding under Section 704 ... " Neither Code Section 704 nor 704.7 specifies whether repeated conduct of not carrying out a contract in good faith constitutes a single act or multiple acts.

Reinsurance contracts typically extend over a period of time and contemplate periodic payments over the life of the contract. The ceding insurer sends settlement reports to the reinsurer at least quarterly and perhaps more frequently if required by the reinsurance agreement. The settlement report is a statement of premium received and losses paid during the reporting period. Reinsurance agreements typically permit netting of the balances due: if the loss payments exceed the premium received during the reporting period, the settlement report bills the reinsurer for its share of paid losses; if the premium received exceeds the losses paid, the ceding insurer remits the reinsurer's share of the premium.

Under the terms of the reinsurance agreement, the reinsurer is required to pay the ceding insurer, within a specified time period, the amount shown due on the settlement report. Consistent with its obligation to carry out its contracts in good faith, the reinsurer is obligated to make timely payment of that amount, unless it has sufficient reason to deny or withhold payment. Each settlement report covers a different time period and requires a separate response from the reinsurer. If a reinsurer denies or withholds payment of an amount reported due on a settlement report without sufficient justification, it is reasonable to provide that each breach of each payment obligation as it becomes due constitutes a separate act of failing to carry out a contract in good faith.

This subdivision provides that for purposes of calculating the fine permitted by Code Section 704.7, each failure by a reinsurer to make timely payment of the amount stated in a settlement report shall constitute a separate violation if either of the conditions specified in subdivision (a) of this section exists with regard to such unpaid amount. Unless separate sanctions are applied to each separate settlement report, a reinsurer could calculate that the risk of a sanction is well worth the benefit to be gained by a violation. For example, if the aggregate sum reported due from a reinsurer over the course of a year totaled $5 Million, the interest earned by withholding payment would far exceed the cost of one $55,000 fine. The availability of separate sanctions for each failure to make a timely payment without sufficient justification will promote timely payments under reinsurance contracts and reduce the instances of arbitrary acts causing adverse consequences to ceding insurers.

This subdivision is reasonably necessary to interpret and make specific Code Sections 704 and 704.7 by specifying that a reinsurer's exposure for separate acts that pertain to one or more reinsurance contracts is not limited to $55,000.

§2303.20(d) This subdivision provides that acts of a licensed insurer other than those specified in subdivision (a) of this section may also constitute violations of Code Section 704. This section applies only to the obligation of a reinsurer to pay amounts due under a reinsurance contract. This subdivision is reasonably necessary to clarify that a breach of other contract obligations may also violate Code Section 704. This subdivision is reasonably necessary to clarify and make specific Code Section 704.

§ 2303.21 INSURER DEFAULT FOR FAILURE TO COMPLY

This section defines the term "governmental control" used in Code Section 701 concerning an insurer's default for failure to comply with the laws of this state, and clarifies the application of that section to the requirements of this article.

Insurance Code section 701 provides, in pertinent part, as follows:

> [W]henever the commissioner shall determine, after notice and hearing, that any insurer to whom such certificate [of authority] has been issued ... is ... in default for failure to comply with any of the laws of this State regarding the governmental control of such insurer by the State, he may order that such insurer comply with the said [sic] requirements within 30 days of such determination. If the insurer fails to comply within such period, the certificate of authority may then be revoked ... "

Code Section 701 does not define the term "governmental control." However, statutes and regulations are the only means which government could exert control over an insurer. Therefore, the term, "failure to comply with any of the laws of this State regarding the governmental control of such insurer by the State," must necessarily include the statutes and regulations in the California Insurance Code and Chapter 5 of Title 10 of the California Code of Regulations.

For example, Code Section 700(c) controls a licensee by requiring it to continuously meet the licensing requirements of Code Section 717. Code Sections 922.1 through 923 control a licensee by requiring it to account for reinsurance in its financial statements in a prescribed manner. And Code Section 1011 controls detrimental conduct of an insurer by permitting the Commissioner to take formal control of the insurer for specified acts. An insurer's violation of any of these statutes, or the regulations interpreting and implementing them, is a failure to comply with the governmental control of that insurer.

To clarify the intent and application of Code Section 701, subdivision (a) of this section provides that as used in Code Section 701, "governmental control" includes the requirements placed upon licensed insurers by this article. Subdivision (b) of this section provides that a violation by a licensed insurer of any requirement of this article shall constitute a failure to comply with the laws of this State regarding governmental control.

Section 701 provides a mechanism for enforcement of the governmental control of an insurer. After a noticed hearing on the issue of noncompliance, the Commissioner may issue a formal order requiring compliance within 30 days. Should the licensee continue to fail to

comply, the Commissioner may revoke the insurer's license to transact insurance in California, unless the formal order to comply is stayed by a court of appropriate jurisdiction. The notice and hearing procedure with an order to comply within 30 days is an appropriate means to enforce regulations that are promulgated for purposes that include safeguarding the solvency of licensed insurers and protecting the interests of the insurer's policyholders and creditors. This section is reasonably necessary to clarify, interpret and implement Code Section 701.

§2303.22 FILING REQUIREMENTS

This section provides instructions to make the various filings required or permitted by this article.

§2303.22(a) This subdivision provides that all costs and expenses incurred by the Department in connection with the review of an application, request or filing made under this article by or on behalf of an insurer or reinsurance intermediary in excess of any deposit paid shall be billed to the insurer or reinsurance intermediary making the application, request or filing. Code Section 736 provides that the cost of all examinations undertaken by the Commissioner is to be paid from the support appropriation of the Department of Insurance, but is to be " ... charged to and collected from the insurer, organization or person examined. For the reasons explained in Section 2303.2(j) of this document, "examination" is defined as including a review of any nature, scope or frequency by the Department. This subdivision is necessary to ensure that the Department recovers all costs of examinations performed pursuant to the requirements of Code Section 736.

This subdivision also provides that the Commissioner shall maintain a schedule of the deposits required under this article on the Department's website and, after 90 days notice provided on the website schedule, may revise the deposit amounts as necessary to substantially cover the expected costs of review. The Commissioner has determined it appropriate to require deposits to be submitted with the various filings required or permitted by this article. The filings require examination by the Department, for which the insurer or intermediary will be required to pay the examination costs. The Commissioner has determined it prudent to require a deposit to cover a reasonable portion of the expected examination cost. A deposit will reduce the number of filings withdrawn because the licensee changed its plans; withdrawn applications or filings cause unnecessary work for Department examiners. Notwithstanding that payment may be received, the need to assign examination personnel to a filing withdrawn because it was perhaps submitted prematurely takes time away from the review of filings which will be pursued to completion. Moreover, deposits reduce the amount of examination costs carried by the Department until the costs are recovered. Over time the Commissioner may determine that the deposits required by these regulations are insufficient to substantially cover the costs of the examinations. Providing notice of revised deposit amounts on the Department's public website is an efficient method to notify interested persons of increased deposits without the necessity of amending the regulations.

This subdivision is reasonably necessary to interpret and make specific Code Section 736.

§2303.22(b) This subdivision defines a term used in Code Section 924, which assesses late fees for the failure to make timely filings. Code Section 924 provides, in pertinent part:

> "The Commissioner shall collect a late filing fee … from any admitted insurer that fails to make and file in the commissioner's office within the time prescribed by law any statements or stipulations required by this code…."

Code Section 924 does not define the term "statements or stipulations." Following is an analysis of the meaning of each word as used in Code Section 924:

Statements

Code Section 924 was contained in the original Insurance Code that was adopted in 1935. At first blush, "statements" seems to refer strictly to financial statements, inasmuch as Code Section 924 is placed within Article 10, commencing at Code Section 900, which states requirements for insurer financial statements. However, upon further analysis, it is clear that the word has a more expansive meaning. First of all, Code Section 924 refers generally to "statements and stipulations" required by the *code.* If the Legislature had chosen to limit the breadth of section 924 to insurer financial statements, it would have used more restrictive language such as "required by this article" instead of "required by this code." Second, if the Legislature intended for "statements and stipulations" to refer only to financial statements, there would be no reason to include the word, "stipulation," as that word does not reasonably relate to financial statements.

Further, it is instructive to look at the Insurance Holding Company System Regulatory Act, codified at Code Sections 1215-1215.16. This Act contains important provisions describing the Commissioner's regulatory control over various transactions between affiliates in a holding company system, and contains an expansive definition of "statement." Specifically, the insurer must allow the Commissioner an opportunity to review in advance those transactions involving any "purchases, exchanges, mergers and other acquisitions of control . . ." (Code Section 1215.2(d).) The vehicle for the Commissioner's review is the insurer's comprehensive "statement" containing statutorily prescribed components (see specifically Code Sections 1215(a)(1) through (5).). In these sections, "statement" obviously does not mean simply a financial statement, although the latter could be part of the required submission; "statement" refers to a comprehensive submission of information describing the proposed transaction. It is reasonable therefore for "statement" in Section 924 to have both the narrow meaning of "financial statement" and also a broader meaning similar to the "statement" prescribed in the Holding Company Act that an insurer is required to file for the Commissioner's prior review.

Stipulations

Code Section 924 provides, in pertinent part:

> "The Commissioner shall collect a late filing fee of three hundred thirty-six dollars ($366) from any admitted insurer that fails to make and file in the commissioner's office within the time prescribed by law any … *stipulations* required by this code…."

(Emphasis added.)

The Code provides no definition for the word, "stipulation."[3] The "stipulations" referenced in Code Section 924 are required to be filed by a licensee with the Commissioner within a prescribed time period. Therefore, "stipulations" cannot mean the "stipulations" used in legal proceedings to resolve points of contention, since there are no filing requirements for such documents in the Code. The dictionary defines "stipulation" as "a condition, requirement, or item specified in a legal instrument" in Merriam-Webster Collegiate Dictionary (11th Edition, 2005). As relevant here, "stipulations" would mean, "items specified." Code Section 924 would thus be interpreted to state,

> "The Commissioner shall collect a late filing fee … from any admitted insurer that fails to make and file in the commissioner's office within the time prescribed by law any statements or [*items specified*] required to be filed by this code."

Thus, consistent with the word, "statement," stipulations would include all filings that are required by the Code, or by regulations interpreting and implementing Code provisions, to be filed with the Commissioner within prescribed time periods.

Conclusion

Code Section 924 is not limited in application to Article 10; it expressly applies to all "statements and stipulations" required to be filed with the Commissioner. Therefore, "statements" as used in Code Section 924 is not limited to the financial statements prescribed

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[3] The only "stipulation" expressly required by the Code to be filed with the Commissioner is found in Code Sections 160, 1604 and 10845 relating to agents for service of process. Code Sections 1601 and 1604 were contained with Code Section 924 in the original Insurance Code that was adopted in 1935 and are therefore relevant to an analysis of the intent of Code Section 924. Code Section 1604 prescribes the text of a "stipulation or agreement" wherein the insurer appoints the Commissioner as its agent for service of process when it is without a designated agent Code Section 1601 provides, in pertinent part:

> "…(T)he Commissioner shall require the payment of twenty-nine dollars ($29) in lawful money of the United States in advance as a fee for filing appointment of agent or stipulation or both by every admitted foreign or alien insurer, under this article."

It is clear that the "stipulations" referenced in Code Section 924 does not refer to the stipulation required to be filed pursuant to the above referenced sections. The late fee penalty of $366 is inappropriate to assess against a filing with a fee of only $29. And the filings required by the cited sections are "appointment of agent or stipulation or both." Code Section 924 could not be interpreted to assess a late fee for a stipulation but not for the appointment of agent – a document with the same intent and import. Moreover, there is no prescribed time period within which to make the agent for service of process filing in order to assess a late filing fee; the filings are required to be included in the application for admission and to replace an appointed agent. Finally, of all the filings required by the Code of greater significance, it cannot be said that the word "stipulations" in Code Section 924 was intended to reference the stipulations filed by foreign insurers to appoint the Commissioner as agent for service of process.

by Article 10, but would include filings made in the form of statements of fact, such as the statements prescribed by Code Section 1215.2(a), where specified information concerning a proposed transaction is required to be filed with the Commissioner for his prior review and either consent or non-objection. To give effect to the word "stipulations" used in Code Section 924, the word must necessarily encompass the filing of transactions that require the Commissioner's prior consent.

This subdivision provides that as used in Code Section 924, the term "statements or stipulations" shall include all filings required by this article and the filings required by Code Section 1011.5. Many of the filings provided for in this article are permissive, not required. For example, applications for Accredited Reinsurer, Approved U.S. Trust, and intermediary examinations are filings that would not be subject to late filing fees. However, filings that are required, such as applications for consent to 75% reinsurance transactions would be subject to late filing fees. The required filings are of such significance that the assessment of a late filing fee is an appropriate sanction for delay. This subdivision is reasonably necessary to clarify and make specific Code Section 924.

§2303.22(c) This subdivision provides that the initial application and annual filings required by Section 2303.4 of this article for accredited reinsurers shall be submitted in duplicate, except that only one copy of specified items are required, accompanied by a deposit of $1,500.00. Duplicate filings permit contemporaneous review of the application by the Department's financial and legal staff. Code Section 922.4(b)(4) requires the applicant to pay all costs and expenses incurred by the Department in conjunction with the review. The deposit requirement is discussed in subdivision (a) of this section. This subdivision is reasonably necessary to clarify and implement Code Section 922.4(b).

§2303.22(d) This subdivision provides that the initial application and annual filings required by Section 2303.5 for an approved U.S. trust, and an application for approval of trust amendments, shall be submitted in duplicate, except that only one copy of specified items are required, accompanied by a specified deposit. The requesting reinsurer or group of insurers shall provide the Department with a $3,000 deposit in conjunction with the initial application for approval of a U.S. trust, a $500 deposit for review of an amendment to the form of an approved U.S. trust, and a $1,500 deposit with the annual filing**.** Duplicate filings permit contemporaneous review of the application by the Department's financial and legal staff. Code Section 922.4(c)(5) requires the applicant to pay all costs and expenses incurred by the Department in conjunction with the review. The deposit requirement is discussed in subdivision (a) of this section. This subdivision is reasonably necessary to clarify and implement Code Section 922.4(c).

§2303.22(e) This subdivision provides that a deposit of $500 shall accompany examination requests made pursuant to Section 2303.8(e) for a determination that a letter of credit form meets the requirements of Section 2303.8(c). The deposit requirement is discussed in subdivision (a) of this section. This subdivision is reasonably necessary to clarify and implement Code Section 922.5(b).

§2303.22(f) This subdivision provides that the applications for consent to specified

reinsurance transactions required by Section 2303.15(e) of this article and applications for the determination required by Section 2303.15(h) of this article shall be submitted for examination in duplicate, accompanied by a deposit of $1,500. Duplicate filings permit contemporaneous review of the application by the Department's financial and legal staff. Pursuant to Code Section 736, the licensed insurer shall pay the costs and expenses of examinations. The deposit requirement is discussed in subdivision (a) of this section. This subdivision is reasonably necessary to clarify and make specific Code Sections 700(c), 717(d), 736, 1011(c), and 1011.5,

§2303.22(g) This subdivision provides that applications for the consent required by Section 2303.15(d) or (e) of this article concerning reinsurance agreements subject to Code Section 1011(c) shall be submitted in duplicate, accompanied by the fee required for an application made under Code Section 1011.5. The applications required by Section 2303.15(d) and (e) are the applications required by Code Section 1011.5, and the fee is set by that statute. Duplicate filings permit contemporaneous review of the application by the Department's financial and legal staff. This subdivision is reasonably necessary to clarify and make Code Section 1011.5.

§2303.22(h) This subdivision provides that a filing for the examination required by Section 2303.15(m) of this article for a determination of compliance with Code Section 700(c) shall include all supporting documents required for an initial application for a Certificate of Authority, shall be made in duplicate, and shall be accompanied by a deposit of $1,500. Section 2303.15(m) of this article is applicable to licensed insurers for which all or most of the documents filed with the Department on behalf of the insurer are no longer valid or current due to a sale of the corporate charter, change in ownership or some other significant change in an insurer's operations.

The documents required for the initial application for a Certificate of Authority are necessary to make a determination of whether the applicant meets the Code Section 717 requirements for licensing. The same documents must be reviewed to determine that a licensee continues to meet licensing requirements. Duplicate filings permit contemporaneous review of the application by the Department's financial and legal staff. Pursuant to Code Section 736, a licensed insurer shall pay the costs and expenses of examination. The deposit requirement is discussed in subdivision (a) of this section. This subdivision is reasonably necessary to clarify and make specific Code Sections 700(c) and 717.

§2303.22(i) This subdivision provides that applications made pursuant to Section 2303.17 of this article for the examination of a reinsurance intermediary shall be submitted in duplicate, accompanied by a deposit of $1,000. Duplicate filings permit contemporaneous review of the application by the Department's financial and legal staff. Pursuant to Code Section 736, a licensed insurer shall pay the costs and expenses of examination. The deposit requirement is discussed in subdivision (a) of this section. This subdivision is reasonably necessary to clarify and make specific Code Section 1781.10.

§2303.22(j) This subdivision provides the addresses for submitting the applications, annual filings and requests made pursuant to subdivisions (c) through (i) of this section.

§ 2303.23 SEVERABILITY

This subdivision provides that if any provision of this article, or the application of a provision to any person or circumstance, shall be held invalid, the remainder of the article, and the application of the provision to persons or circumstances other than those to which it is held invalid, shall not be affected.

This section is reasonably necessary to permit regulation provisions that are valid and independent of other provisions to go into effect in the event a provision of the regulations is held to be invalid.

§2303.24 EFFECTIVE DATE

This section specifies when the regulations become effective as to various transactions and matters, and incorporates Bulletin 97-5 by reference for a limited purpose. This section is reasonably necessary for efficient implementation of the regulations.

§2303.24(a) This subdivision provides that Section 2303 through Section 2303.25 of this article shall become effective on July 1, 2006, or the 60th day following the day those sections are filed with the Secretary of State, whichever is later (the "Effective Date").

The regulations introduce comprehensive provisions regarding reinsurance accounting and transactions. The Commissioner has determined that a reasonable period of time is needed for licensees and other affected persons to prepare for compliance. Many licensees have general familiarity with the scope of the requirements through participation of their trade associations in the development of the regulations. However, licensees will need to analyze the new requirements, train staff, develop forms, and take other steps to ensure compliance. Accordingly, a date that is more than six months after the regulations have been proposed has been selected as the earliest effective date.

The subdivision also provides that Section 2303.15(k) becomes effective one year after the date when all other sections of the regulations become effective. Section 2303.15(k) provides that the Commissioner may condition consent for a transaction upon a reinsurance intermediary having a satisfactory examination report by the Commissioner. Such examinations are not currently required and no examinations of intermediaries have been performed. The one-year delay will permit the orderly scheduling and completion of the financial examinations of intermediaries which request examination.

§2303.24(b) This subdivision provides that no licensee may claim reserve credit for any reinsurance agreement entered into or renewed on or after the Effective Date unless the agreement and the security provided therefor conform to the requirements of this article.

Except as specifically provided, the regulations will not apply to reinsurance agreements that are in effect prior to the Effective Date. Reinsurance contracts can be in effect for very long

periods of time; for example, reinsurance contracts that cover environmental exposures can remain in effect for decades. Ceding insurers that took statement credit for agreements prior to the effective date of these regulations may not be able to obtain agreement from their reinsurers to modify existing agreements to conform to the regulations. For this reason, the regulations are prospective.

However, the subdivision also provides that no licensee may claim reserve credit for any material reinsurance agreement, as defined in Section 2303.2(q), that is materially amended on or after the Effective Date unless the agreement and the security provided therefor conform to the requirements of this article. As used in this subdivision, a "material" amendment is one that can reasonably be expected to change the ceding insurer's premium or liabilities by an amount equal to or greater than 1% of its policyholder surplus as reported on its most recent statutory financial statement. An amendment to an existing agreement will require consent of the reinsurer. Therefore, if the parties desire to amend an existing agreement in a manner that will result in a material change to the ceding insurer's premium or liabilities, the agreement and any security provided will be required to conform to the regulations. Since the regulations include many requirements intended to safeguard the solvency of the licensee and protect the interests of its policyholders and creditors, it is appropriate to require compliance to existing agreements when those agreements are amended.

§2303.24(c) This subdivision provides that licensees shall follow the requirements of Bulletin 97-5, issued pursuant to Code Section 922.8, until the Effective Date. On and after the Effective Date, all reinsurance agreements and security that are not made subject to the requirements of this article pursuant to subdivision (b) of this section shall remain subject to the requirements of Bulletin 97-5. The subdivision provides that Bulletin 97-5 is incorporated in the regulations by reference for that limited purpose. This subdivision is reasonably necessary to clarify that Bulletin 97-5 continues to apply to reinsurance transactions that are not subject to these regulations (that is, agreements that pre-date the Effective Date).

§2303.24(d) This subdivision provides that licensees shall continue to conform to the requirements of the NAIC Accounting Guidance, to the extent that those requirements do not conflict with applicable requirements of the Code and Bulletin 97-5, or, after the Effective Date, with this article. Code Section 923 requires licensees to comply with the NAIC Accounting Guidance, to the extent its requirements are not in conflict with the Code or are modified by the Commissioner. This subdivision is reasonably necessary to clarify that the regulations (and Bulletin 97-5) do not supercede the NAIC Accounting Guidance, except as specifically provided for.

§2303.25 APPROVED FORMS

This section provides forms that are required or permitted by the regulations. The Certificate of Assuming Insurer Form AR-1 as published in this section is required under Section 2303.4 and 2303.5 of this article. The Designation of Agent for Service of Process and Consent to Jurisdiction Form AR-2 as published in this section is a form acceptable to the Commissioner

under the requirements of Sections 2303.4, 2303.5, 2303.7, and 2303.8 of this article. The Letter of Credit for Reinsurance Form AR-3 as published in this section is a form acceptable to the commissioner for the purpose of securing ceded reinsurance under Section 2303.8 of this article.

A required or permitted form is less burdensome to the insurer in not having to create a document to comply with the requirements. A required or permitted form is more efficient for the Department to determine whether statutory requirements have been met. The forms are reasonably necessary for the efficient and effective implementation of Code Sections 922.4(b) and (c) and 922.5(b).

ECONOMIC IMPACT ON SMALL BUSINESS

The Commissioner has identified no reasonable alternatives to the presently proposed regulations, nor have any such alternatives otherwise been identified and brought to the attention of the Department, that would lessen any impact on small business. The only small businesses which the proposed regulations are anticipated to potentially affect are licensed reinsurance intermediaries, as discussed below. Although performance standards were considered as an alternative, they were rejected, in part, because they are inapplicable in light of the regulations' purpose of prescribing accounting rules, contract provisions, and examination procedures to safeguard a licensed insurer's solvency.

With respect to a licensed reinsurance intermediary, certain intermediaries will undergo financial examination by the Department. The cost of such an examination will be borne by the intermediary, and is estimated to be approximately $51,000. The Commissioner estimates that approximately 10 intermediaries will be examined in the year following the effective date of the regulations. An examination of an intermediary would be performed every three years. A licensed intermediary may be considered a small business. The Commissioner has determined there is no reasonable alternative to the presently proposed regulations with respect to examination of intermediaries. Licensed reinsurance intermediary brokers are presently not independently audited. An independent examination by a Certified Public Account would be far more expensive to the intermediary than the proposed examination by the Department. No other state or federal regulator examines reinsurance intermediaries, notwithstanding that the intermediaries that would be examined under the regulations handle billions of dollars annually in transfer payments between insurers and reinsurers.

IDENTIFICATION OF STUDIES

There are no specific studies relied upon in the adoption of the proposed regulations.

SPECIFIC TECHNOLOGIES OR EQUIPMENT

Adoption of these regulations would not mandate the use of specific technologies or equipment.

ALTERNATIVES

The Commissioner has determined that no reasonable alternative exists to carry out the purposes for which the regulations are proposed.

PRENOTICE PUBLIC DISCUSSIONS

The Commissioner conducted prenotice public discussions pursuant to Government Code §11346.45 on September 27, 2004. Input obtained in connection with the workshop was considered in formulating the proposed regulations.